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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 410. RADIATION MANAGEMENT

[OAR Docket #10-555]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

- Subchapter 5. Certification of Industrial Radiographers
252:410-5-3. DEQ certification examination [AMENDED]
- Subchapter 7. Radiation Management Authorizations; Procedures and Requirements
- Part 1. General Provisions Common to All Authorizations
252:410-7-3. General application requirements [AMENDED]
- Subchapter 10. Radioactive Materials Program
- Part 101. Radioactive Materials Program Fees
252:410-10-101. Fee schedules [AMENDED]
252:410-10-102. Fees for special nuclear materials licensing [AMENDED]
252:410-10-103. Fees for source material licensing [AMENDED]
252:410-10-104. Fees for byproduct material licensing [AMENDED]
252:410-10-105. Fees for waste disposal and processing [AMENDED]
252:410-10-106. Fees for well logging [AMENDED]
252:410-10-107. Fees for nuclear laundries [AMENDED]
252:410-10-108. Fees for human use of byproduct, source or special material licensing [AMENDED]
252:410-10-109. Fees for civil defense activities [AMENDED]
252:410-10-111. Fees for small entities [AMENDED]
252:410-10-114. Full cost fees [AMENDED]
252:410-10-118. Reciprocity fees [AMENDED]
- Subchapter 19. X-Ray Fluorescence Instruments Used for Lead-based Paint Detection
252:410-19-6. LBP-XRF permit application fee [AMENDED]
- Appendix A. Application and Annual Fee Schedule for Radiation Machines [REVOKED]
- Appendix A. Application and Annual Fee Schedule for Radiation Machines [NEW]

SUMMARY:

The purpose of the proposed rule is to increase revenue to meet program costs and, thereafter, provide an annual fee

adjustment to assist in meeting rising costs to the DEQ for implementation of radiation management programs. Fees in every category for both materials licenses and permits are increased by fifteen percent (15%). A new fee is proposed for materials licensees authorizing two or more locations of use or storage. The new fee is twenty-five percent (25%) of the base fee per additional site, capped at four sites. The fee for industrial radiography certification will be changed to reflect the cost of acquiring and administering the test. The fee will be the same for both initial and renewed certifications.

The annual fee adjustment will apply to every category of licenses, permits, and industrial radiographer certification. Fees shall be automatically adjusted annually on the first day of July to correspond to the percentage, if any, by which the Consumer Price Index (CPI) for the most recent calendar year exceeds the CPI for the previous calendar year. The DEQ may waive collection of an automatic increase in a given year if it determines other revenues make the funds generated by the automatic adjustment unnecessary in that year. A waiver does not affect future automatic adjustments.

AUTHORITY:

Environmental Quality Board and Radiation Management Advisory Council powers and duties, 27A O.S. "2-2-101, 2-2-104, 2-2-201, 2-9-104, and 2-9-105.

COMMENT PERIOD:

Written comments may be delivered or mailed to the contact person from May 3, 2010, through June 9, 2010. Oral comments may be made at the Radiation Management Advisory Council meeting on June 10, 2010, and the Environmental Quality Board meeting in February, 2011 (date and time yet to be determined).

PUBLIC HEARINGS:

Before the Radiation Management Advisory Council at 10:00 a.m. on June 10, 2010, in room A-229 of the Tulsa Tech building on the Jenks airport.

Before the Environmental Quality Board in February, 2011 (date and time yet to be determined) in the Multi-Purpose Room, first floor of the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma 73102.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The DEQ requests that business entities affected by this proposed rulemaking provide the DEQ, 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

Notices of Rulemaking Intent

other costs expected to be incurred by a particular entity due to compliance with the proposed rule.

COPIES OF PROPOSED RULES:

The proposed rule may be obtained from the contact person, reviewed in person at the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma, or reviewed online at the DEQ website at www.deq.state.ok.us/LPDnew/LPPProprules.htm.

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 or reviewed online at the DEQ website at www.deq.state.ok.us/LPDnew/LPPProprules.htm.

CONTACT PERSON:

Contact Mike Broderick, Environmental Programs Manager, Radiation Management Section, Land Protection Division at mike.broderick@deq.state.ok.us or (405) 702-5100 (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. The TDD relay number is 1-800-522-8506 or 1-800-722-0353, for TDD machine use only.

[OAR Docket #10-555; filed 4-8-10]

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

[OAR Docket #10-554]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 9. Continuing Education [AMENDED]

SUMMARY:

The proposed amendments clarify the types of continuing education that may be submitted and update the procedures for submitting continuing education for approval for Physical Therapists and Physical Therapist Assistants.

AUTHORITY:

TITLE 59 O.S., §§ 887.4, 887.5, 887.12, State Board of Medical Licensure and Supervision

COMMENT PERIOD:

The comment period will run from May 3, 2010 to July 30, 2010. Written comments may be sent to the office of the Board, PO Box 18256, Oklahoma City, OK 73154-0256.

PUBLIC HEARING:

A public hearing will be held to provide an opportunity for persons to orally present their views on August 5, 2010, 9:00 a.m. at the office of the Board, 101 N.E. 51st Street, Oklahoma City, Oklahoma. Written notice of intent to make oral comment must be received by this office no later than July 30, 2010.

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, 101 N.E. 51st Street, Oklahoma City, Oklahoma.

RULE IMPACT STATEMENT:

A rule impact statement will be prepared and available after May 3, 2010 at the office of the Board, 101 N.E. 51st Street, Oklahoma City, Oklahoma, 73105.

CONTACT PERSON:

Kathy Plant, Executive Secretary (405) 962-1400, ext. 122

[OAR Docket #10-554; filed 4-8-10]

Submissions for Review

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

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

TITLE 75. ATTORNEY GENERAL CHAPTER 15. STANDARDS AND CRITERIA FOR DOMESTIC VIOLENCE, AND SEXUAL ASSAULT AND BATTERERS INTERVENTION PROGRAMS

[OAR Docket #10-450]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 15. Standards and Criteria For Domestic Violence, and Sexual Assault and Batters Intervention Programs [AMENDED]

SUBMITTED TO GOVERNOR:

March 29, 2010

SUBMITTED TO HOUSE:

March 29, 2010

SUBMITTED TO SENATE:

March 29, 2010

[OAR Docket #10-450; filed 3-30-10]

TITLE 75. ATTORNEY GENERAL CHAPTER 25. STANDARDS AND CRITERIA FOR BATTERERS INTERVENTION PROGRAMS

[OAR Docket #10-451]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 25. Standards and Criteria For Batters Intervention Programs [NEW]

SUBMITTED TO GOVERNOR:

March 29, 2010

SUBMITTED TO HOUSE:

March 29, 2010

SUBMITTED TO SENATE:

March 29, 2010

[OAR Docket #10-451; filed 3-30-10]

TITLE 87. OKLAHOMA STATE EMPLOYEES BENEFITS COUNCIL CHAPTER 10. FLEXIBLE BENEFITS PLAN

[OAR Docket #10-494]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 28. Early Medical Alert Optional Benefit [NEW]

87:10-28-1. Early medical alert optional benefit [NEW]

87:10-28-2. Definitions [NEW]

87:10-28-3. Requirements for participation [NEW]

87:10-28-4. Internal Revenue Code and regulations [NEW]

87:10-28-5. Period of coverage- enrollment [NEW]

87:10-28-6. Enrollment [NEW]

87:10-28-7. Early medical alert account option [NEW]

SUBMITTED TO GOVERNOR:

March 31, 2010

SUBMITTED TO HOUSE:

March 31, 2010

SUBMITTED TO SENATE:

March 31, 2010

[OAR Docket #10-494; filed 4-5-10]

TITLE 87. OKLAHOMA STATE EMPLOYEES BENEFITS COUNCIL CHAPTER 10. FLEXIBLE BENEFITS PLAN

[OAR Docket #10-495]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 24. Health Savings Account [NEW]

87:10-24-1. Health Savings Account [NEW]

87:10-24-2. Definitions [NEW]

87:10-24-3. Requirements for eligibility [NEW]

87:10-24-4. Amount of benefits available [NEW]

87:10-24-5. Internal Revenue Code and regulations [NEW]

87:10-24-6. Mid-year changes of benefits [NEW]

87:10-24-7. Health Savings Account option [NEW]

87:10-24-8. Claims for reimbursement [NEW]

87:10-24-9. Forfeiture of unused benefits [NEW]

87:10-24-10. Other governing provisions [NEW]

87:10-24-11. Benefit changes [NEW]

87:10-24-12. Report to participants [NEW]

Submissions for Review

SUBMITTED TO GOVERNOR:

March 31, 2010

SUBMITTED TO HOUSE:

March 31, 2010

SUBMITTED TO SENATE:

March 31, 2010

[OAR Docket #10-495; filed 4-5-10]

**TITLE 120. CAPITOL-MEDICAL
CENTER IMPROVEMENT AND ZONING
COMMISSION
CHAPTER 10. ZONING REGULATIONS
FOR CAPITOL-MEDICAL CENTER
IMPROVEMENT AND ZONING DISTRICT**

[OAR Docket #10-473]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions

120:10-1-3. [AMENDED]

Subchapter 3. Specific District Regulations

120:10-3-1 [REVOKED]

120:10-3-1.1 [NEW]

120:10-3-2 [REVOKED]

120:10-3-2.1 [NEW]

120:10-3-3 [REVOKED]

120:10-3-3.1 [NEW]

120:10-3-4 [REVOKED]

120:10-3-4.1 [NEW]

120:10-3-5 [REVOKED]

120:10-3-5.1 [NEW]

120:10-3-6 [REVOKED]

120:10-3-6.1 [NEW]

120:10-3-7 [REVOKED]

120:10-3-7.1 [NEW]

120:10-3-9 [REVOKED]

120:10-3-9.1 [NEW]

120:10-3-10 [REVOKED]

120:10-3-10.1 [NEW]

120:10-3-11 [REVOKED]

120:10-3-11.1 [NEW]

Subchapter 5. General District Provision and Additional
Zoning Regulations [AMENDED]

120:10-5-1.1 [REVOKED]

120:10-5-1.2 [NEW]

120:10-5-2 [REVOKED]

120:10-5-2.1 [NEW]

120:10-5-3 [REVOKED]

120:10-5-3.1 [NEW]

120:10-5-4 [REVOKED]

120:10-5-4.1 [NEW]

120:10-5-5 [REVOKED]

120:10-5-5.1 [NEW]

120:10-5-6 [REVOKED]

120:10-5-6.1 [NEW]

120:10-5-9 [REVOKED]

120:10-5-9.1 [NEW]

120:10-5-10 [REVOKED]

120:10-5-10.1 [NEW]

120:10-5-11 [REVOKED]

120:10-5-11.1 [NEW]

120:10-5-12 [REVOKED]

120:10-5-12.1 [NEW]

120:10-5-14 [AMENDED]

Subchapter 9. Non-conforming Buildings, Structures and
Uses of Land

120:10-9-1 [REVOKED]

120:10-9-1.1 [NEW]

Subchapter 11. Historical Preservation and Landmark
Board of Review

120:10-11-1 [REVOKED]

120:10-11-1.1 [NEW]

120:10-11-2 [REVOKED]

120:10-11-2.1 [NEW]

120:10-11-3 [REVOKED]

120:10-11-3.1 [NEW]

120:10-11-5 [REVOKED]

120:10-11-5.1 [NEW]

120:10-11-6 [REVOKED]

120:10-11-6.1 [NEW]

120:10-11-7 [REVOKED]

120:10-11-7.1 [NEW]

120:10-11-8 [REVOKED]

120:10-11-8.1 [NEW]

120:10-11-9 [REVOKED]

120:10-11-9.1 [NEW]

120:10-11-10 [REVOKED]

120:10-11-10.1 [NEW]

120:10-11-11 [REVOKED]

120:10-11-11.1 [NEW]

Subchapter 13. Administration [AMENDED]

120:10-13-1 [REVOKED]

120:10-13-1.1 [NEW]

120:10-13-2 [REVOKED]

120:10-13-2.1 [NEW]

120:10-13-3 [REVOKED]

120:10-13-3.1 [NEW]

120:10-13-4 [REVOKED]

120:10-13-4.1 [NEW]

120:10-13-5 [REVOKED]

120:10-13-5.1 [NEW]

120:10-13-6 [REVOKED]

120:10-13-6.1 [NEW]

120:10-13-7 [REVOKED]

120:10-13-7.1 [NEW]

120:10-13-8 [REVOKED]

120:10-13-8.1 [NEW]

120:10-13-9 [REVOKED]

120:10-13-9.1 [NEW]

120:10-13-10 [REVOKED]
120:10-13-10.1 [NEW]
120:10-13-11 [REVOKED]
120:10-13-11.1 [NEW]
120:10-13-12 [REVOKED]
120:10-13-12.1 [NEW]
Appendix A. Capitol-Medical Center Improvement and Zoning District Maps [REVOKED]
Appendix A.1. Capitol-Medical Center Improvement and Zoning District Maps [NEW]
Appendix B. Official Height Zoning Map [REVOKED]
Appendix B.1. Official Height Zoning Map [NEW]
Appendix C. State Capitol Complex Subdistrict [REVOKED]
Appendix C.1. State Capitol complex Subdistrict [NEW]
Appendix F. Comprehensive Master Plan - 1978 [NEW]
Appendix G. Comprehensive Plan Update - 1994 [NEW]

SUBMITTED TO GOVERNOR:

December 28, 2009

SUBMITTED TO HOUSE:

December 28, 2009

SUBMITTED TO SENATE:

December 28, 2009

[OAR Docket #10-473; filed 4-1-10]

**TITLE 120. CAPITOL-MEDICAL CENTER IMPROVEMENT AND ZONING COMMISSION
CHAPTER 10. ZONING REGULATIONS FOR CAPITOL-MEDICAL CENTER IMPROVEMENT AND ZONING DISTRICT**

[OAR Docket #10-496]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Specific District Regulations
120:10-3-13. [AMENDED]
Subchapter 5. General District Provision and Additional Zoning Regulations
120:10-5-14. [AMENDED]
Subchapter 13. Administration
120:10-13-1 through 120:10-13-12.1 [REVOKED]
120:10-13-13 through 120:10-13-22 [NEW]

SUBMITTED TO GOVERNOR:

March 29, 2010

SUBMITTED TO HOUSE:

March 29, 2010

SUBMITTED TO SENATE:

March 29, 2010

[OAR Docket #10-496; filed 4-5-10]

**TITLE 165. CORPORATION COMMISSION
CHAPTER 5. RULES OF PRACTICE**

[OAR Docket #10-476]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 5. Rules of Practice [AMENDED]

SUBMITTED TO GOVERNOR:

March 31, 2010

SUBMITTED TO HOUSE:

March 31, 2010

SUBMITTED TO SENATE:

March 31, 2010

[OAR Docket #10-476; filed 4-1-10]

**TITLE 165. CORPORATION COMMISSION
CHAPTER 10. OIL AND GAS CONSERVATION**

[OAR Docket #10-478]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Appendix C. Table HD [REVOKED]
Appendix C. Table HD [NEW]
Appendix F. Schedule B Fines [REVOKED]
Appendix F. Schedule B Fines [NEW]

SUBMITTED TO GOVERNOR:

March 31, 2010

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March 31, 2010

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March 31, 2010

[OAR Docket #10-478; filed 4-1-10]

**TITLE 165. CORPORATION COMMISSION
CHAPTER 35. ELECTRIC UTILITY RULES**

[OAR Docket #10-477]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 34. Competitive Procurement
165:35-34-3. RFP Competitive Bidding Procurement Process [AMENDED]
Subchapter 37. Integrated Resource Planning
165:35-37-4. Integrated Resource Plan Reviews [AMENDED]

Submissions for Review

165:35-37-5. Procedure for Subsequent Integrated Resource Plans [NEW]

Subchapter 38. Recoverable Costs

165:35-38-3. Transmission Upgrades [AMENDED]

165:35-38-4. Capital Expenditures to Meet Environmental Requirements [AMENDED]

165:35-38-5. Self-build or Purchase Options [AMENDED]

SUBMITTED TO GOVERNOR:

March 31, 2010

SUBMITTED TO HOUSE:

March 31, 2010

SUBMITTED TO SENATE:

March 31, 2010

[OAR Docket #10-477; filed 4-1-10]

TITLE 277. FORENSIC REVIEW BOARD
CHAPTER 1. FORENSIC REVIEW BOARD

[OAR Docket #10-531]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 1. Forensic Review Board [NEW]

SUBMITTED TO GOVERNOR:

March 31, 2010

SUBMITTED TO HOUSE:

March 31, 2010

SUBMITTED TO SENATE:

March 31, 2010

[OAR Docket #10-531; filed 4-6-10]

TITLE 300. GRAND RIVER DAM
AUTHORITY
CHAPTER 20. PURCHASING POLICY

[OAR Docket #10-467]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

300:20-1-1. [AMENDED]

300:20-1-2. [AMENDED]

300:20-1-3. [AMENDED]

300:20-1-4. [AMENDED]

300:20-1-5. [AMENDED]

300:20-1-6. [AMENDED]

300:20-1-7. [AMENDED]

300:20-1-8. [AMENDED]

300:20-1-9. [AMENDED]

300:20-1-10. [AMENDED]

300:20-1-11. [AMENDED]

300:20-1-12. [AMENDED]

300:20-1-13. [AMENDED]

300:20-1-14. [AMENDED]

300:20-1-16. [AMENDED]

SUBMITTED TO GOVERNOR:

March 26, 2010

SUBMITTED TO HOUSE:

March 26, 2010

SUBMITTED TO SENATE:

March 26, 2010

[OAR Docket #10-467; filed 3-31-10]

TITLE 300. GRAND RIVER DAM
AUTHORITY
CHAPTER 35. LAKE RULES

[OAR Docket #10-468]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 1. Definitions, Purpose and Application

300:35-1-1. [AMENDED]

300:35-1-5. [AMENDED]

300:35-1-6. [AMENDED]

Subchapter 3. General Provisions

300:35-3-5. [AMENDED]

300:35-3-6. [REVOKED]

300:35-3-12. [AMENDED]

300:35-3-14. [NEW]

300:35-3-15. [NEW]

Subchapter 5. Boating Safety Rules

300:35-5-1. [AMENDED]

300:35-5-2. [AMENDED]

300:35-5-3. [AMENDED]

300:35-5-4. [AMENDED]

300:35-5-7. [AMENDED]

Subchapter 7. Vessels

300:35-7-1. [AMENDED]

300:35-7-2. [AMENDED]

300:35-7-4. [AMENDED]

300:35-7-5. [AMENDED]

300:35-7-8. [AMENDED]

300:35-7-12. [AMENDED]

Subchapter 9. Sanctioned Events

300:35-9-2. [AMENDED]

Subchapter 11. Permits for Wharves, Landings, Buoys,

Breakwaters and Docking Facilities

300:35-11-1. [AMENDED]

300:35-11-2. [AMENDED]

300:35-11-4. [AMENDED]

300:35-11-5. [AMENDED]

300:35-11-6. [AMENDED]

300:35-11-7. [AMENDED]

300:35-11-8. [AMENDED]

- 300:35-11-11. [AMENDED]
- 300:35-11-12. [AMENDED]
- Subchapter 13. Permits for Dikes, Excavations, Dredgings, Erosion Control Devices, Retaining Walls, and Shoreline Stabilization
- 300:35-13-1. [AMENDED]
- 300:35-13-2. [AMENDED]
- 300:35-13-3. [AMENDED]
- 300:35-13-4. [AMENDED]
- 300:35-13-5. [REVOKED]
- 300:35-13-6. [AMENDED]
- Subchapter 15. Commercial Use of the Lakes and Lands of GRDA
- 300:35-15-1. [AMENDED]
- 300:35-15-2. [AMENDED]
- 300:35-15-3. [REVOKED]
- 300:35-15-4. [AMENDED]
- 300:35-15-5. [REVOKED]
- 300:35-15-6. [AMENDED]
- 300:35-15-7. [REVOKED]
- Subchapter 17. Raw Water Permits
- 300:35-17-1. [AMENDED]
- 300:35-17-2. [AMENDED]
- Subchapter 21. Administration of Rules and Hearings
- 300:35-21-3. [AMENDED]
- 300:35-21-4. [AMENDED]
- 300:35-21-7. [AMENDED]
- Subchapter 27. Vegetation Management Plan
- 300:35-27-3. [AMENDED]

SUBMITTED TO GOVERNOR:

March 26, 2010

SUBMITTED TO HOUSE:

March 26, 2010

SUBMITTED TO SENATE:

March 26, 2010

[OAR Docket #10-468; filed 3-31-10]

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

[OAR Docket #10-586]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULE:

325:25-1-30 [AMENDED]

SUBMITTED TO GOVERNOR:

April 2, 2010

SUBMITTED TO HOUSE:

April 2, 2010

SUBMITTED TO SENATE:

April 2, 2010

[OAR Docket #10-586; filed 4-9-10]

**TITLE 325. OKLAHOMA HORSE RACING COMMISSION
CHAPTER 75. OKLAHOMA-BRED PROGRAM**

[OAR Docket #10-587]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULE:

325:75-1-12 [AMENDED]

325:75-1-12.1 [AMENDED]

325:75-1-13.1 [AMENDED]

325:75-1-16 [AMENDED]

SUBMITTED TO GOVERNOR:

April 2, 2010

SUBMITTED TO HOUSE:

April 2, 2010

SUBMITTED TO SENATE:

April 2, 2010

[OAR Docket #10-587; filed 4-9-10]

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

[OAR Docket #10-461]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. Office of the Executive Director

Part 3. Office of the Advocate General

377:3-1-21. Definitions [AMENDED]

377:3-1-23. Job duties [AMENDED]

377:3-1-25. Abuse, neglect, and caretaker misconduct of a child in OJA custody and placed in a secure facility or other facility operated by or through contract with OJA [AMENDED]

377:3-1-26. Advocate General procedures during an abuse, neglect, or caretaker misconduct investigation for other than OJA secure institution [AMENDED]

SUBMITTED TO THE GOVERNOR:

March 31, 2010

SUBMITTED TO THE HOUSE:

March 31, 2010

Submissions for Review

SUBMITTED TO THE SENATE:

March 31, 2010

[OAR Docket #10-461; filed 3-31-10]

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

[OAR Docket #10-462]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. Office of the Executive Director
[AMENDED]

Subchapter 5. Office of Human Resources Management
[AMENDED]

Subchapter 13. Office of Public Integrity [AMENDED]

SUBMITTED TO THE GOVERNOR:

March 31, 2010

SUBMITTED TO THE HOUSE:

March 31, 2010

SUBMITTED TO THE SENATE:

March 31, 2010

[OAR Docket #10-462; filed 3-31-10]

**TITLE 377. OFFICE OF JUVENILE AFFAIRS
CHAPTER 35. INSTITUTIONAL SERVICES**

[OAR Docket #10-463]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions

377:35-1-2. Definitions [REVOKED]

Subchapter 3. Security and Control

377:35-3-7. Contraband and Facility Prohibited Items
[REVOKED]

377:35-3-8. Searches and control of contraband/evidence
[REVOKED]

SUBMITTED TO THE GOVERNOR:

March 31, 2010

SUBMITTED TO THE HOUSE:

March 31, 2010

SUBMITTED TO THE SENATE:

March 31, 2010

[OAR Docket #10-463; filed 3-31-10]

**TITLE 380. DEPARTMENT OF LABOR
CHAPTER 50. ABATEMENT OF FRIABLE
ASBESTOS MATERIALS RULES**

[OAR Docket #10-449]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions [AMENDED]

Subchapter 4. Project Design Requirements [AMENDED]

Subchapter 5. Contractor, Supervisor, and Worker
Licensing and Requirements [AMENDED]

Subchapter 6. Training Requirements [AMENDED]

Subchapter 9. Contractor Procedures [AMENDED]

Subchapter 11. Laboratory Requirements [AMENDED]

Subchapter 13. Glovebag Operations [AMENDED]

Subchapter 15. Worker and Work Area Protection
[AMENDED]

Subchapter 17. Minimum Abatement Standards
[AMENDED]

Subchapter 19. Variances [AMENDED]

Subchapter 21. Non-Friable Asbestos Containing Material
Procedures [REVOKED]

Subchapter 23. Miscellaneous Friable Asbestos Material
Abatement Procedures [AMENDED]

SUBMITTED TO GOVERNOR:

March 29, 2010

SUBMITTED TO HOUSE:

March 29, 2010

SUBMITTED TO SENATE:

March 29, 2010

[OAR Docket #10-449; filed 3-29-10]

**TITLE 390. COUNCIL ON LAW
ENFORCEMENT EDUCATION AND
TRAINING
CHAPTER 10. PEACE OFFICER
CERTIFICATION**

[OAR Docket #10-497]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

390:10-1-5 [AMENDED]

SUBMITTED TO GOVERNOR:

March 24, 2010

SUBMITTED TO HOUSE:

March 24, 2010

SUBMITTED TO SENATE:

March 24, 2010

[OAR Docket #10-497; filed 4-5-10]

**TITLE 390. COUNCIL ON LAW ENFORCEMENT EDUCATION AND TRAINING
CHAPTER 15. BASIC PEACE OFFICER CERTIFICATION TRAINING**

[OAR Docket #10-498]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- Subchapter 1. Basic Academy Programs
- 390:15-1-2 [AMENDED]
- 390:15-1-6 [AMENDED]
- 390:15-1-11 [REVOKED]
- 390:15-1-12 [REVOKED]
- 390:15-1-13 [AMENDED]
- 390:15-1-14 [REVOKED]
- 390:15-1-15 [REVOKED]
- 390:15-1-16 [REVOKED]
- 390:15-1-17 [REVOKED]

SUBMITTED TO GOVERNOR:

March 24, 2010

SUBMITTED TO HOUSE:

March 24, 2010

SUBMITTED TO SENATE:

March 24, 2010

[OAR Docket #10-498; filed 4-5-10]

**TITLE 390. COUNCIL ON LAW ENFORCEMENT EDUCATION AND TRAINING
CHAPTER 20. RESERVE PEACE OFFICER CERTIFICATION AND TRAINING**

[OAR Docket #10-499]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

PROPOSED RULES:

- 390:20-1-3 [AMENDED]
- 390:20-1-4 [AMENDED]
- 390:20-1-8 [AMENDED]
- 390:20-1-11 [AMENDED]
- 390:20-1-12 [AMENDED]

SUBMITTED TO GOVERNOR:

March 24, 2010

SUBMITTED TO HOUSE:

March 24, 2010

SUBMITTED TO SENATE:

March 24, 2010

[OAR Docket #10-499; filed 4-5-10]

**TITLE 390. COUNCIL ON LAW ENFORCEMENT EDUCATION AND TRAINING
CHAPTER 35. REGULATION OF PRIVATE SECURITY INDUSTRY**

[OAR Docket #10-500]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- Subchapter 5. License Requirements
- 390:35-5-13 [AMENDED]
- Subchapter 9. Violations and Investigations
- 390:35-9-4 [AMENDED]
- Subchapter 15. Training Standards and Requirements
- Appendix A. Disqualifying Convictions [REVOKED]
- Appendix A. Disqualifying Convictions [NEW]

SUBMITTED TO GOVERNOR:

March 24, 2010

SUBMITTED TO HOUSE:

March 24, 2010

SUBMITTED TO SENATE:

March 24, 2010

[OAR Docket #10-500; filed 4-5-10]

**TITLE 390. COUNCIL ON LAW ENFORCEMENT EDUCATION AND TRAINING
CHAPTER 50. PENALTY ASSESSMENT FEES**

[OAR Docket #10-501]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- 390:50-1-5 [AMENDED]

SUBMITTED TO GOVERNOR:

March 24, 2010

SUBMITTED TO HOUSE:

March 24, 2010

SUBMITTED TO SENATE:

March 24, 2010

[OAR Docket #10-501; filed 4-5-10]

Submissions for Review

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

[OAR Docket #10-527]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 1. Administration [AMENDED]

SUBMITTED TO GOVERNOR:

March 30, 2010

SUBMITTED TO HOUSE:

March 30, 2010

SUBMITTED TO SENATE:

March 30, 2010

[OAR Docket #10-527; filed 4-6-10]

**TITLE 450. DEPARTMENT OF MENTAL
HEALTH AND SUBSTANCE ABUSE
SERVICES
CHAPTER 17. STANDARDS AND CRITERIA
FOR COMMUNITY MENTAL HEALTH
CENTERS**

[OAR Docket #10-528]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 17. Standards and Criteria for Community Mental Health Centers [AMENDED]

SUBMITTED TO GOVERNOR:

March 30, 2010

SUBMITTED TO HOUSE:

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[OAR Docket #10-528; filed 4-6-10]

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

[OAR Docket #10-529]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

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

SUBMITTED TO GOVERNOR:

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**TITLE 450. DEPARTMENT OF MENTAL
HEALTH AND SUBSTANCE ABUSE
SERVICES
CHAPTER 50. STANDARDS AND CRITERIA
FOR CERTIFIED BEHAVIORAL HEALTH
CASE MANAGERS**

[OAR Docket #10-530]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions

450:50-1-2. Definitions [AMENDED]

Subchapter 3. Behavioral Health Case Manager Certification Application

450:50-3-1. Qualifications for certification [AMENDED]

450:50-3-2. Applications for certification [AMENDED]

450:50-3-3. Duration of certification [AMENDED]

450:50-3-4. Fees [AMENDED]

450:50-3-5. Fitness of applicants [AMENDED]

450:50-3-7. Classifications of Certified Behavioral Health Case Managers [NEW]

Subchapter 5. Behavioral Health Case Manager Certification Training and Web-based Competency Exam

450:50-5-1. Case management certification training [AMENDED]

450:50-5-4. Continuing education requirements [AMENDED]

450:50-5-5. Web-based competency exam [NEW]

Subchapter 7. Rules of Professional Conduct

450:50-7-1. Responsibility and scope of practice [AMENDED]

450:50-7-2. Consumer welfare [AMENDED]

450:50-7-3. Reimbursement for services rendered [AMENDED]

450:50-7-4. Professional standards [AMENDED]

450:50-7-5. Failure to comply [AMENDED]

Subchapter 9. Enforcement

450:50-9-1. Enforcement [AMENDED]

Subchapter 11. Complaint Process and Investigation/resolution of Complaints [NEW]

450:50-11-1. Complaints of Professional Conduct [NEW]

450:50-11-2. Reviewing complaints [NEW]
450:50-11-3. Investigation [NEW]
450:50-11-4. Filing of an action [NEW]

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**TITLE 460. DEPARTMENT OF MINES
CHAPTER 20. THE PERMANENT
PROGRAM REGULATIONS GOVERNING
THE COAL RECLAMATION ACT OF 1979**

[OAR Docket #10-535]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 20. The Permanent Regulations Governing The
Coal Reclamation Act of 1979 [AMENDED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #10-535; filed 4-7-10]

**TITLE 545. BOARD OF PODIATRIC
MEDICAL EXAMINERS
CHAPTER 15. EXAMINATION/LICENSURE**

[OAR Docket #10-526]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 15. Examination/Licensure
545:15-1-2. Examination [AMENDED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #10-526; filed 4-5-10]

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

[OAR Docket #10-472]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 2. General Provisions

580:15-2-1. [AMENDED]

580:15-2-2. [AMENDED]

580:15-2-3. [AMENDED]

580:15-2-4. [AMENDED]

580:15-2-5. [AMENDED]

580:15-2-6. [AMENDED]

580:15-2-7. [AMENDED]

580:15-2-8. [AMENDED]

580:15-2-9. [AMENDED]

580:15-2-11. [AMENDED]

580:15-2-12. [NEW]

Subchapter 4. Supplier Provisions

580:15-4-1. [REVOKED]

580:15-4-2. [AMENDED]

580:15-4-4. [AMENDED]

580:15-4-5. [AMENDED]

580:15-4-6. [AMENDED]

580:15-4-7. [AMENDED]

580:15-4-9. [AMENDED]

580:15-4-11.1. [NEW]

580:15-4-13. [AMENDED]

580:15-4-14. [AMENDED]

580:15-4-15. [AMENDED]

580:15-4-16. [REVOKED]

580:15-4-18. [AMENDED]

580:15-4-19. [AMENDED]

Subchapter 6. State Agency Provisions

580:15-6-1. [REVOKED]

580:15-6-2. [AMENDED]

580:15-6-3. [AMENDED]

580:15-6-4. [REVOKED]

580:15-6-5. [AMENDED]

580:15-6-6. [AMENDED]

580:15-6-6.1. [NEW]

580:15-6-6.2. [NEW]

580:15-6-10. [AMENDED]

580:15-6-14. [AMENDED]

580:15-6-15. [AMENDED]

580:15-6-18. [AMENDED]

580:15-6-19. [AMENDED]

580:15-6-20. [AMENDED]

580:15-6-21. [AMENDED]

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Submissions for Review

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**TITLE 580. DEPARTMENT OF CENTRAL SERVICES
CHAPTER 25. RISK MANAGEMENT PROGRAM**

[OAR Docket #10-470]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 5. Casualty or Liability Claims Management,
Payment and Reports

580:25-5-1. [AMENDED]

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[OAR Docket #10-470; filed 4-1-10]

**TITLE 580. DEPARTMENT OF CENTRAL SERVICES
CHAPTER 35. FLEET MANAGEMENT DIVISION**

[OAR Docket #10-471]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

580:35-1-1 [AMENDED]

580:35-1-7 [AMENDED]

580:35-1-8 [AMENDED]

580:35-1-10 [AMENDED]

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**TITLE 580. DEPARTMENT OF CENTRAL SERVICES
CHAPTER 55. COMMITTEE OF ALTERNATIVE FUELS TECHNICIAN EXAMINERS**

[OAR Docket #10-469]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

580:55-1-2 [AMENDED]

580:55-1-7 [AMENDED]

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

[OAR Docket #10-479]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

PROPOSED RULES:

Subchapter 3. Public Policy

Part 3. Taxpayer Identification

710:1-3-6 [AMENDED]

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[OAR Docket #10-479; filed 4-1-10]

**TITLE 710. OKLAHOMA TAX COMMISSION
CHAPTER 10. AD VALOREM**

[OAR Docket #10-480]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

PROPOSED RULES:

Subchapter 7. Manufacturing Facilities

710:10-7-2.2. [AMENDED]

710:10-7-5. [AMENDED]
710:10-7-11. [AMENDED]
710:10-7-15. [AMENDED]
710:10-7-17. [AMENDED]

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[OAR Docket #10-480; filed 4-1-10]

**TITLE 710. OKLAHOMA TAX
COMMISSION
CHAPTER 45. GROSS PRODUCTION**

[OAR Docket #10-481]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

PROPOSED RULES:

Subchapter 9. Exemptions and Exclusions
Part 5. Horizontally Drilled Production Wells
710:45-9-21. [AMENDED]
710:45-9-24. [AMENDED]
Part 7. Incremental Production from Enhanced Recovery
Projects or Properties
710:45-9-31. [AMENDED]
710:45-9-32.1. [AMENDED]
710:45-9-34. [AMENDED]
710:45-9-35. [AMENDED]
Part 9. Production Enhancement Projects
710:45-9-40. [AMENDED]
710:45-9-41. [AMENDED]
Part 11. Reestablishment of Production from an Inactive
Well
710:45-9-51. [AMENDED]
Part 13. Deep Wells
710:45-9-60. [AMENDED]
Part 15. New Discovery Wells
710:45-9-70. [AMENDED]
710:45-9-71. [AMENDED]
710:45-9-73. [AMENDED]
Part 19. Production Using Three Dimensional Seismic
Shoots
710:45-9-90. [AMENDED]
710:45-9-92. [AMENDED]
710:45-9-93. [AMENDED]

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[OAR Docket #10-481; filed 4-1-10]

**TITLE 710. OKLAHOMA TAX
COMMISSION
CHAPTER 50. INCOME**

[OAR Docket #10-482]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

PROPOSED RULES:

Subchapter 3. Returns and Reports
Part 5. Filing Status; Elections; Accounting Periods and
Methods
710:50-3-45. [AMENDED]
710:50-3-46. [AMENDED]
Subchapter 9. Refunds
710:50-9-3. [AMENDED]
Subchapter 15. Oklahoma Taxable Income
Part 3. Exemptions
710:50-15-35. [NEW]
Part 5. Other Adjustments to Income
710:50-15-47. [NEW]
710:50-15-50. [AMENDED]
710:50-15-53. [AMENDED]
710:50-15-68. [NEW]
Part 7. Credits Against Tax
710:50-15-74. [AMENDED]
710:50-15-81. [AMENDED]
710:50-15-83. [AMENDED]
710:50-15-86. [AMENDED]
710:50-15-87. [AMENDED]
Subchapter 17. Oklahoma Taxable Income for
Corporations
Part 5. Determination of Taxable Corporate Income
710:50-17-51. [AMENDED]
Part 7. Apportionment and Allocation of Corporate Income
and Expense
710:50-17-71. [AMENDED]

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[OAR Docket #10-482; filed 4-1-10]

Submissions for Review

TITLE 710. OKLAHOMA TAX COMMISSION CHAPTER 60. MOTOR VEHICLES

[OAR Docket #10-483]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

PROPOSED RULES:

Subchapter 3. Registration and Licensing

Part 1. General Provisions

710:60-3-10. [AMENDED]

710:60-3-12. [AMENDED]

710:60-3-17. [AMENDED]

710:60-3-18. [AMENDED]

710:60-3-21. [AMENDED]

Part 3. Penalties

710:60-3-30. [AMENDED]

710:60-3-31. [AMENDED]

710:60-3-33. [AMENDED]

710:60-3-34. [AMENDED]

710:60-3-35. [AMENDED]

710:60-3-36. [AMENDED]

Part 9. Commercial Vehicles

710:60-3-91. [AMENDED]

Part 11. Other Vehicles

710:60-3-111. [AMENDED]

Part 13. Manufactured Homes

710:60-3-134. [AMENDED]

Part 14. All-Terrain Vehicles, Off-Road Motorcycles and
Utility Vehicles

710:60-3-141. [AMENDED]

710:60-3-142. [AMENDED]

Part 15. Special License Plates

710:60-3-150. [AMENDED]

710:60-3-151. [AMENDED]

Subchapter 5. Motor Vehicle Titles

Part 5. Certificates of Title

710:60-5-55. [AMENDED]

710:60-5-62 [NEW]

Part 7. Transfer of Title

710:60-5-71. [AMENDED]

710:60-5-74. [AMENDED]

710:60-5-77. [AMENDED]

Part 9. Affidavits for Use in Titles

710:60-5-91. [AMENDED]

710:60-5-96. [AMENDED]

Part 11. Liens

710:60-5-116. [AMENDED]

Subchapter 9. Motor Vehicle License Agents/Agencies

Part 1. General Requirements, Duties and Responsibilities
of Motor License Agents

710:60-9-14. [AMENDED]

Part 9. Specific Fiscal Duties

710:60-9-94. [AMENDED]

710:60-9-97. [AMENDED]

Part 13. ~~Special Provisions for Motor License Agent
Application, Qualification, and Appointment And
Agency Operation Applicable To Certain Motor License
Agents And Agencies~~

710:60-9-130. [REVOKED]

710:60-9-130.1. [NEW]

710:60-9-131. [AMENDED]

710:60-9-133. [AMENDED]

710:60-9-134. [AMENDED]

710:60-9-135. [REVOKED]

710:60-9-137. [AMENDED]

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

[OAR Docket #10-484]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

PROPOSED RULES:

Subchapter 1. General Provisions

710:65-1-2. [AMENDED]

710:65-1-8. [AMENDED]

710:65-1-9. [AMENDED]

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

Part 1. General Provisions

710:65-3-8. [AMENDED]

Part 3. Records and Recordkeeping

710:65-3-32. [AMENDED]

710:65-3-33. [AMENDED]

Subchapter 7. Duties and Liabilities

710:65-7-13. [AMENDED]

710:65-7-16. [AMENDED]

710:65-7-21. [NEW]

710:65-7-22. [RESERVED]

710:65-7-23. [RESERVED]

710:65-7-24. [RESERVED]

710:65-7-25. [NEW]

Subchapter 9. Permits

710:65-9-8. [AMENDED]

Subchapter 13. Sales and Use Tax Exemptions

Part 7. Churches

710:65-13-33. [AMENDED]

710:65-13-40. [AMENDED]

Part 10. Coal

710:65-13-55. [AMENDED]
Part 13. Contractors Refund; Change of Rates
710:65-13-70. [AMENDED]
Part 15. Hazardous Wastes
710:65-13-80. [AMENDED]
Part 23. Gas and Electricity
710:65-13-120. [AMENDED]
Part 25. Governmental Entities
710:65-13-130. [AMENDED]
710:65-13-133. [AMENDED]
Part 29. Manufacturing
710:65-13-150.1. [AMENDED]
710:65-13-157. [AMENDED]
Part 31. Medicine, Medical Appliances, and Health Care
Entities and Activities
710:65-13-169. [AMENDED]
710:65-13-172. [AMENDED]
710:65-13-173. [AMENDED]
710:65-13-174. [AMENDED]
710:65-13-175. [AMENDED]
710:65-13-177. [AMENDED]
Part 35. NEWspapers; Periodicals; Programs; Media
710:65-13-194. [AMENDED]
Part 37. Sales for Resale
710:65-13-200. [AMENDED]
Part 39. Schools and Higher Education
710:65-13-210. [AMENDED]
710:65-13-220. [AMENDED]
Part 43. Social, Charitable, and Civic Organizations and
Activities
710:65-13-334. [AMENDED]
710:65-13-335. [AMENDED]
710:65-13-336. [AMENDED]
710:65-13-337. [AMENDED]
710:65-13-338. [AMENDED]
710:65-13-339. [AMENDED]
710:65-13-340. [AMENDED]
710:65-13-341. [AMENDED]
710:65-13-342. [AMENDED]
710:65-13-343. [AMENDED]
710:65-13-344. [AMENDED]
710:65-13-345. [AMENDED]
710:65-13-346. [AMENDED]
710:65-13-348. [AMENDED]
710:65-13-350. [AMENDED]
710:65-13-351. [AMENDED]
710:65-13-352. [AMENDED]
710:65-13-353. [AMENDED]
710:65-13-354. [AMENDED]
710:65-13-355. [AMENDED]
710:65-13-357. [AMENDED]
710:65-13-359. [AMENDED]
710:65-13-360. [AMENDED]
710:65-13-361. [RESERVED]
710:65-13-362. [NEW]
Part 55. Trust Authorities

710:65-13-550. [AMENDED]
Subchapter 18. Sourcing Pursuant to the Streamlined Sales
and Use Tax Administration Act
710:65-18-5. [AMENDED]
Subchapter 19. Specific Applications and Examples
Part 5. "C"
710:65-19-52. [AMENDED]
Part 7. "D"
710:65-19-72. [AMENDED]
710:65-19-74. [AMENDED]
Part 11. "F"
710:65-19-114. [AMENDED]
Part 17. "I"
710:65-19-156. [AMENDED]
Part 31. "P"
710:65-19-259. [AMENDED]
Part 39. " T "
710:65-19-328. [AMENDED]
710:65-19-329. [AMENDED]
Part 41. "U"
710:65-19-341. [AMENDED]
Subchapter 21. Use Tax
710:65-21-2. [AMENDED]
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[OAR Docket #10-484; filed 4-1-10]

**TITLE 710. OKLAHOMA TAX
COMMISSION
CHAPTER 70. TOBACCO, TOBACCO
PRODUCTS, AND CIGARETTES**

[OAR Docket #10-485]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
PROPOSED RULES:
Subchapter 2. Cigarette Stamp Tax
Part 1. General Provisions
710:70-2-3. [AMENDED]
710:70-2-4. [AMENDED]
710:70-2-8. [AMENDED]
710:70-2-9. [AMENDED]
710:70-2-9.1. [AMENDED]
710:70-2-11. [AMENDED]
710:70-2-14. [NEW]
Subchapter 5. Excise on Tobacco Products
710:70-5-2. [AMENDED]
710:70-5-3. [AMENDED]
710:70-5-4. [AMENDED]

Submissions for Review

710:70-5-6. [AMENDED]
710:70-5-8. [AMENDED]
710:70-5-9. [AMENDED]
710:70-5-10. [AMENDED]
710:70-5-13. [AMENDED]
710:70-5-14. [NEW]
Subchapter 7. Cigarette and Tobacco Products Sales by
Federally-Recognized Indian Tribes and Nations
710:70-7-4. [AMENDED]
710:70-7-5. [AMENDED]
710:70-7-7. [REVOKED]
710:70-7-8. [AMENDED]
710:70-7-9. [AMENDED]
710:70-7-10. [NEW]

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

[OAR Docket #10-486]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

PROPOSED RULES:

Subchapter 1. Oklahoma Quality Jobs Program
710:85-1-8. [AMENDED]
Subchapter 5. Small Employer Quality Jobs Program
710:85-5-9. [AMENDED]
Subchapter 11. 21st Century Quality Jobs Program [NEW]
710:85-11-1. [NEW]
710:85-11-2. [NEW]
710:85-11-3. [NEW]
710:85-11-4. [NEW]
710:85-11-5. [NEW]
710:85-11-6. [NEW]
710:85-11-7. [NEW]
710:85-11-8. [NEW]
710:85-11-9. [NEW]
710:85-11-10. [NEW]

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**TITLE 710. OKLAHOMA TAX
COMMISSION
CHAPTER 90. WITHHOLDING**

[OAR Docket #10-487]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

PROPOSED RULES:

Subchapter 3. Returns and Payments
710:90-3-4 [AMENDED]

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

[OAR Docket #10-488]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

PROPOSED RULES:

Subchapter 15. Wire Transmitter Fee [NEW]
710:95-15-1. [NEW]
710:95-15-2. [NEW]
710:95-15-3. [NEW]
710:95-15-4. [NEW]
710:95-15-5. [NEW]
710:95-15-6. [NEW]

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

[OAR Docket #10-460]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review.

RULES:

Subchapter 6. Definitions [NEW]
765:37-6-1 [NEW]
Subchapter 7. Installation Standards For Ground Sets
765:37-7-1 [AMENDED]
765:37-7-2 [AMENDED]

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[OAR Docket #10-460; filed 3-31-10]

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

[OAR Docket #10-508]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions
785:5-1-6. Stream water permit application and
administration fees [AMENDED]
785:5-1-9. Dam safety and inspection fees [AMENDED]
785:5-1-10. Groundwater application and administration
fees [AMENDED]
785:5-1-11. Well driller and pump installer licensing fees
[AMENDED]
785:5-1-14. Stream water and groundwater petition fees
[AMENDED]

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[OAR Docket #10-508; filed 4-5-10]

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

[OAR Docket #10-509]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions
785:20-1-6. Who should file an application [AMENDED]
Subchapter 3. Application Requirements and Processing
785:20-3-2. General application requirements
[AMENDED]
Appendix A. Application for a Permit to Use Surface or
Stream Water [REVOKED]
Appendix A. Application for a Permit to Use Surface or
Stream Water [NEW]

SUBMITTED TO GOVERNOR:

February 19, 2010

SUBMITTED TO HOUSE:

February 19, 2010

SUBMITTED TO SENATE:

February 19, 2010

[OAR Docket #10-509; filed 4-5-10]

**TITLE 785. OKLAHOMA WATER
RESOURCES BOARD
CHAPTER 25. DAMS AND RESERVOIRS**

[OAR Docket #10-510]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions
785:25-1-2. Definitions [AMENDED]
785:25-1-4. Variances and waivers [AMENDED]
Subchapter 3. Responsibility, Classification and Design
Standards
785:25-3-3. Classification of size and hazard potential
[AMENDED]
785:25-3-4. Dams considered unsafe and a menace to life
and property [AMENDED]
785:25-3-5. Minimum design standards (other than
spillway) [AMENDED]
785:25-3-10. Prohibited vegetation and erosion
[AMENDED]
Subchapter 5. Applications and Approval of Construction
785:25-5-3. Content of plans and specifications
[AMENDED]
785:25-5-5. Notice of application [AMENDED]
785:25-5-6. Affidavit of notice publication and mailing
[AMENDED]

Submissions for Review

785:25-5-7. Protest and public comment [AMENDED]
Subchapter 7. Post Approval Actions
785:25-7-5. Changes to plans and specifications after approval [AMENDED]
785:25-7-7. ~~Warning and evacuation~~ Emergency action plans [AMENDED]
Subchapter 9. Actions after Construction
785:25-9-1. ~~Inspections~~ Inspection of dams [AMENDED]
785:25-9-9. Breach analysis for existing dams [NEW]
785:25-9-10. Reclassification of the hazard potential class [NEW]
785:25-9-11. Upgrading dams due to downstream development [NEW]

SUBMITTED TO GOVERNOR:

February 19, 2010

SUBMITTED TO HOUSE:

February 19, 2010

SUBMITTED TO SENATE:

February 19, 2010

[OAR Docket #10-510; filed 4-5-10]

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

[OAR Docket #10-511]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions
785:30-1-4. Requirement for water right [AMENDED]
Subchapter 3. Permit Application Requirements and Processing
785:30-3-6. Well spacing [AMENDED]
Appendix A. Application for a Permit to Use Groundwater [REVOKED]
Appendix A. Application for a Permit to Use Groundwater [NEW]

SUBMITTED TO GOVERNOR:

February 19, 2010

SUBMITTED TO HOUSE:

February 19, 2010

SUBMITTED TO SENATE:

February 19, 2010

[OAR Docket #10-511; filed 4-5-10]

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

[OAR Docket #10-512]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions
785:35-1-2. Definitions [AMENDED]
Subchapter 3. Licensing and Certifications
785:35-3-2. Expiration and renewal of licenses and certifications [AMENDED]
Subchapter 7. Minimum Standards for Construction of Wells
785:35-7-1. Minimum standards for construction of groundwater wells, fresh water observation wells, and water well test holes [AMENDED]
785:35-7-2. Minimum standards for construction of monitoring wells and geotechnical borings [AMENDED]
Subchapter 11. Plugging and Capping Requirements for Wells and Test Holes
785:35-11-2. Plugging requirements for site assessment observation wells, monitoring wells and geotechnical borings [AMENDED]

SUBMITTED TO GOVERNOR:

February 19, 2010

SUBMITTED TO HOUSE:

February 19, 2010

SUBMITTED TO SENATE:

February 19, 2010

[OAR Docket #10-512; filed 4-5-10]

**TITLE 785. OKLAHOMA WATER
RESOURCES BOARD
CHAPTER 45. OKLAHOMA'S WATER
QUALITY STANDARDS**

[OAR Docket #10-513]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions
785:45-1-2. Definitions [AMENDED]
Subchapter 5. Surface Water Quality Standards
Part 1. General Provisions
785:45-5-3. Beneficial uses: default designations [AMENDED]
Part 3. Beneficial Uses and Criteria to Protect Uses
785:45-5-19. Aesthetics [AMENDED]

Appendix E. Requirements for Development of Site-Specific Criteria for Certain Parameters [REVOKED]

Appendix E. Requirements for Development of Site-Specific Criteria for Certain Parameters [NEW]

Appendix G. Numerical Criteria to Protect Beneficial Uses [REVOKED]

Appendix G. Numerical Criteria to Protect Beneficial Uses [NEW]

Appendix H. Beneficial Use Designations for Certain Limited Areas of Groundwater [REVOKED]

Appendix H. Beneficial Use Designations for Certain Limited Areas of Groundwater [NEW]

SUBMITTED TO GOVERNOR:

March 18, 2010

SUBMITTED TO HOUSE:

March 18, 2010

SUBMITTED TO SENATE:

March 18, 2010

[OAR Docket #10-513; filed 4-5-10]

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

[OAR Docket #10-514]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 8. Rural Economic Action Plan (REAP) Grant Program Requirements and Procedures

785:50-8-6. Disbursement of funds [AMENDED]

Subchapter 9. Clean Water State Revolving Fund Regulations

Part 1. General Provisions

785:50-9-9. Definitions [AMENDED]

Part 3. General Program Requirements

785:50-9-23. Clean Water SRF Project Priority System [AMENDED]

785:50-9-35. Loan closing [AMENDED]

785:50-9-45. Compliance with federal authorities [AMENDED]

Part 7. SRF Environmental Review Process

785:50-9-60. Requirement of environmental review [AMENDED]

785:50-9-61. Environmental information required by the Board [AMENDED]

785:50-9-62. Environmental review by the Board [AMENDED]

SUBMITTED TO GOVERNOR:

February 19, 2010

SUBMITTED TO HOUSE:

February 19, 2010

SUBMITTED TO SENATE:

February 19, 2010

[OAR Docket #10-514; filed 4-5-10]

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 10. OKLAHOMA ACCOUNTANCY BOARD CHAPTER 15. LICENSURE AND REGULATION OF ACCOUNTANCY

[OAR Docket #10-534]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions

10:15-1-2. [AMENDED]

Subchapter 3. Requirements to Practice Public Accountancy

10:15-3-2. [AMENDED]

10:15-3-3. [AMENDED]

10:15-3-4. [AMENDED]

Subchapter 18. Computer-based Examination

10:15-18-1. [AMENDED]

10:15-18-4. [AMENDED]

10:15-18-7. [AMENDED]

10:15-18-10. [AMENDED]

10:15-18-11. [AMENDED]

10:15-18-12. [AMENDED]

10:15-18-14. [AMENDED]

10:15-18-15. [NEW]

10:15-18-16. [NEW]

Subchapter 21. Reciprocity

10:15-21-1. [AMENDED]

10:15-21-3. [AMENDED]

10:15-21-5. [AMENDED]

Subchapter 22. Substantial Equivalency

10:15-22-1. [REVOKED]

Subchapter 23. Registration

10:15-23-1. [AMENDED]

10:15-23-2. [AMENDED]

10:15-23-3. [NEW]

Subchapter 25. Permits

10:15-25-1. [AMENDED]

10:15-25-2. [AMENDED]

10:15-25-3. [AMENDED]

10:15-25-4. [AMENDED]

10:15-25-5. [AMENDED]

Subchapter 27. Fees

10:15-27-7.1. [REVOKED]

10:15-27-8. [AMENDED]

10:15-27-9. [AMENDED]

10:15-27-9.1. [NEW]

Subchapter 30. Continuing Professional Education

10:15-30-1. [AMENDED]

10:15-30-5. [AMENDED]

10:15-30-6. [AMENDED]

10:15-30-8. [AMENDED]

10:15-30-9. [AMENDED]

Subchapter 32. Standards for Continuing Professional Education (CPE) Programs

10:15-32-1. [AMENDED]

10:15-32-2. [AMENDED]

10:15-32-5. [AMENDED]

10:15-32-6. [AMENDED]

Subchapter 33. Peer Review

10:15-33-6. [AMENDED]

Subchapter 35. Reinstatement

10:15-35-1. [AMENDED]

10:15-35-2. [AMENDED]

Subchapter 37. Enforcement Procedures

10:15-37-9. [AMENDED]

Subchapter 39. Rules of Professional Conduct

10:15-39-1. [AMENDED]

10:15-39-8. [REVOKED]

10:15-39-8.1. [NEW]

10:15-39-8.2. [NEW]

Subchapter 43. Audits Performed in Accordance with Government Auditing Standards

10:15-43-1. [AMENDED]

10:15-43-6. [AMENDED]

10:15-43-8. [AMENDED]

GUBERNATORIAL APPROVAL:

March 25, 2010

[OAR Docket #10-534; filed 4-7-10]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 3. FINE MATRICES

[OAR Docket #10-452]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. Fine Schedules

Part 7. Forestry and Timber Violations [NEW]

35:3-1-7 [NEW]

GUBERNATORIAL APPROVAL:

March 5, 2010

[OAR Docket #10-452; filed 3-30-10]

Gubernatorial Approvals

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

[OAR Docket #10-453]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions
35:15-1-4 [NEW]

GUBERNATORIAL APPROVAL:

March 5, 2010

[OAR Docket #10-453; filed 3-30-10]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 20. FORESTRY

[OAR Docket #10-454]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions
35:20-1-1 [AMENDED]
Subchapter 3. Rural Fire Protection Program Fund Act
Part 1. General Provisions
35:20-3-1 [AMENDED]
Part 3. Financial Assistance Program
35:20-3-5 [AMENDED]
35:-20-3-6 [AMENDED]
35:20-3-7 [REVOKED]
35:20-3-8 through 35:20-3-11 [AMENDED]
Part 5. Matching Grant Program
35:20-3-17 through 35:20-3-24 [AMENDED]
Part 7. Rural Fire Defense Equipment Revolving Fund Program
35:20-3-30 through 35:20-3-34 [AMENDED]
Subchapter 17. Forest Resources Development Program
Part 1. General Provisions
35:20-17-1 [AMENDED]
35:20-17-2 [AMENDED]
Part 3. Cost-Share Program Guidelines
35:20-17-7 through 35:20-17-9 [AMENDED]
35:20-17-14 through 35:20-17-16 [AMENDED]
35:20-17-19 [AMENDED]
35:20-17-21 through 35:20-17-23 [AMENDED]

GUBERNATORIAL APPROVAL:

March 5, 2010

[OAR Docket #10-454; filed 3-30-10]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 30. CONSUMER PROTECTION

[OAR Docket #10-455]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 27. Feed
Part 1. Commercial Feed
35:30-27-9.1 [NEW]

GUBERNATORIAL APPROVAL:

March 5, 2010

[OAR Docket #10-455; filed 3-30-10]

TITLE 120. CAPITOL-MEDICAL CENTER IMPROVEMENT AND ZONING COMMISSION CHAPTER 10. ZONING REGULATIONS FOR CAPITOL-MEDICAL CENTER IMPROVEMENT AND ZONING DISTRICT

[OAR Docket #10-474]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions [AMENDED]
120:10-1-3. [AMENDED]
Subchapter 3. Specific District Regulations [AMENDED]
120:10-3-1 [REVOKED]
120:10-3-1.1 [NEW]
120:10-3-2 [REVOKED]
120:10-3-2.1 [NEW]
120:10-3-3 [REVOKED]
120:10-3-3.1 [NEW]
120:10-3-4 [REVOKED]
120:10-3-4.1 [NEW]
120:10-3-5 [REVOKED]
120:10-3-5.1 [NEW]
120:10-3-6 [REVOKED]
120:10-3-6.1 [NEW]
120:10-3-7 [REVOKED]
120:10-3-7.1 [NEW]
120:10-3-9 [REVOKED]
120:10-3-9.1 [NEW]
120:10-3-10 [REVOKED]
120:10-3-10.1 [NEW]
120:10-3-11 [REVOKED]
120:10-3-11.1 [NEW]
Subchapter 5. General District Provision and Additional Zoning Regulations [AMENDED]
120:10-5-1.1 [REVOKED]
120:10-5-1.2 [NEW]

- 120:10-5-2 [REVOKED]
- 120:10-5-2.1 [NEW]
- 120:10-5-3 [REVOKED]
- 120:10-5-3.1 [NEW]
- 120:10-5-4 [REVOKED]
- 120:10-5-4.1 [NEW]
- 120:10-5-5 [REVOKED]
- 120:10-5-5.1 [NEW]
- 120:10-5-6 [REVOKED]
- 120:10-5-6.1 [NEW]
- 120:10-5-9 [REVOKED]
- 120:10-5-9.1 [NEW]
- 120;10-5-10 [REVOKED]
- 120:10-5-10.1 [NEW]
- 120:10-5-11 [REVOKED]
- 120:10-5-11.1 [NEW]
- 120:10-5-12 [REVOKED]
- 120:10-5-12.1 [NEW]
- 120:10-5-14 [AMENDED]
- Subchapter 9. Non-conforming Buildings, Structures and Uses of Land
- 120:10-9-1 [REVOKED]
- 120:10-9-1.1 [NEW]
- Subchapter 11. Historical Preservation and Landmark Board of Review
- 120:10-11-1 [REVOKED]
- 120:10-11-1.1 [NEW]
- 120:10-11-2 [REVOKED]
- 120:10-11-2.1 [NEW]
- 120:10-11-3 [REVOKED]
- 120:10-11-3.1 [NEW]
- 120:10-11-5 [REVOKED]
- 120:10-11-5.1 [NEW]
- 120:10-11-6 [REVOKED]
- 120:10-11-6.1 [NEW]
- 120:10-11-7 [REVOKED]
- 120:10-11-7.1 [NEW]
- 120:10-11-8 [REVOKED]
- 120:10-11-8.1 [NEW]
- 120:10-11-9 [REVOKED]
- 120:10-11-9.1 [NEW]
- 120:10-11-10 [REVOKED]
- 120:10-11-10.1 [NEW]
- 120:10-11-11 [REVOKED]
- 120:10-11-11.1 [NEW]
- Subchapter 13. Administration
- 120:10-13-1 [REVOKED]
- 120:10-13-1.1 [NEW]
- 120:10-13-2 [REVOKED]
- 120:10-13-2.1 [NEW]
- 120:10-13-3 [REVOKED]
- 120:10-13-3.1 [NEW]
- 120:10-13-4 [REVOKED]

- 120:10-13-4.1 [NEW]
- 120:10-13-5 [REVOKED]
- 120:10-13-5.1 [NEW]
- 120:10-13-6 [REVOKED]
- 120:10-13-6.1 [NEW]
- 120:10-13-7 [REVOKED]
- 120:10-13-7.1 [NEW]
- 120:10-13-8 [REVOKED]
- 120:10-13-8.1 [NEW]
- 120:10-13-9 [REVOKED]
- 120:10-13-9.1 [NEW]
- 120:10-13-10 [REVOKED]
- 120:10-13-10.1 [NEW]
- 120:10-13-11 [REVOKED]
- 120:10-13-11.1 [NEW]
- 120:10-13-12 [REVOKED]
- 120:10-13-12.1 [NEW]
- Appendix A. Capitol-Medical Center Improvement and Zoning District Maps [REVOKED]
- Appendix A.1. Capitol-Medical Center Improvement and Zoning District Maps [NEW]
- Appendix B. Official Height Zoning Map [REVOKED]
- Appendix B.1. Official Height Zoning Map [NEW]
- Appendix C. State Capitol Complex Subdistrict [REVOKED]
- Appendix C.1. State Capitol complex Subdistrict [NEW]
- Appendix F. Comprehensive Master Plan - 1978 [NEW]
- Appendix G. Comprehensive Plan Update - 1994 [NEW]

GUBERNATORIAL APPROVAL:

January 20, 2010

[OAR Docket #10-474; filed 4-1-10]

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

[OAR Docket #10-502]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

Subchapter 5. Fair Hearings
Part 9. Adoption and Foster Care

340:2-5-91 [AMENDED]

(Reference APA WF 09-30)

GUBERNATORIAL APPROVAL:

March 26, 2010

[OAR Docket #10-502; filed 4-5-10]

Gubernatorial Approvals

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

[OAR Docket #10-503]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

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

340:10-2-1 through 340:10-2-4 [AMENDED]

340:10-2-8 [AMENDED]

Subchapter 3. Conditions of Eligibility - Need

Part 1. Resources

340:10-3-5 through 340:10-3-6 [AMENDED]

Part 3. Income

340:10-3-31 [AMENDED]

340:10-3-33 [AMENDED]

Part 5. Assistance Payments

340:10-3-56 [AMENDED]

340:10-3-58 [AMENDED]

Subchapter 9. Conditions of Eligibility - Relationship of Payee to Child

340:10-9-1 [AMENDED]

Subchapter 10. Conditions of Eligibility - Deprivation

340:10-10-1 [AMENDED]

340:10-10-3 [AMENDED]

Subchapter 20. Diversion Assistance

340:10-20-1 [AMENDED]

Subchapter 22. Temporary Assistance for Needy Families (TANF) Supported Permanency Program

340:10-22-1 [AMENDED]

(Reference APA WF 09-07, 09-12, 09-15, 09-26)

GUBERNATORIAL APPROVAL:

March 26, 2010

[OAR Docket #10-503; filed 4-5-10]

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

[OAR Docket #10-504]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

Subchapter 1. Low Income Home Energy Assistance Program

340:20-1-1 [AMENDED]

340:20-1-3 [AMENDED]

340:20-1-10 through 340:20-1-12 [AMENDED]

340:20-1-17 [AMENDED]

340:20-1-19 through 340:20-1-20 [NEW]

(Reference APA WF 09-27)

GUBERNATORIAL APPROVAL:

March 26, 2010

[OAR Docket #10-504; filed 4-5-10]

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

[OAR Docket #10-505]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

Subchapter 3. Initial Application

340:40-3-1 [AMENDED]

Subchapter 7. Eligibility

340:40-7-1 [AMENDED]

340:40-7-6 [AMENDED]

340:40-7-8 through 340:40-7-9 [AMENDED]

340:40-7-11 through 340:40-7-13 [AMENDED]

Subchapter 9. Procedures Relating to Case Changes

340:40-9-1 [AMENDED]

Subchapter 13. Child Care Rates and Provider Issues

340:40-13-2 [AMENDED]

340:40-13-5 [AMENDED]

Subchapter 15. Overpayments

340:40-15-1 [AMENDED]

(Reference APA WF 09-11, 09-16, and 09-28)

GUBERNATORIAL APPROVAL:

March 26, 2010

[OAR Docket #10-505; filed 4-5-10]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 50. SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

[OAR Docket #10-506]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

Subchapter 3. Application Process

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

Subchapter 5. Non-Financial Eligibility Criteria

Part 1. Household Definition

340:50-5-2 [AMENDED]

340:50-5-10.1 [AMENDED]

Part 3. Special Households

340:50-5-30 [AMENDED]
 Part 5. Students, Strikers, Resident Farm Laborers, Migrant Households, Sponsored Aliens, and School Employees
 340:50-5-45 [AMENDED]
 340:50-5-48 [AMENDED]
 Part 7. Related Provisions
 340:50-5-64.1 [AMENDED]
 Part 9 Work Registration
 340:50-5-91 through 340:50-5-94 [AMENDED]
 340:50-5-96 [AMENDED]
 Subchapter 7. Financial Eligibility Criteria
 Part 3. Income
 340:50-7-22 [AMENDED]
 340:50-7-29 through 340:50-7-31 [AMENDED]
 Part 5. Determination of Income
 340:50-7-45 through 340:50-7-46 [AMENDED]
 Subchapter 9. Eligibility and Benefit Determination Procedures
 340:50-9-1 [AMENDED]
 Subchapter 10. Electronic Benefit Transfer (EBT)
 340:50-10-1 [AMENDED]
 340:50-10-9 [AMENDED]
 340:50-10-11 [AMENDED]
 Subchapter 11. Special Procedures
 Part 1. Households Entitled to Expedited Service
 340:50-11-1 [AMENDED]
 Part 3. Simplified ~~Food~~ Stamp Supplemental Nutrition Assistance Program (~~SFSP~~ SSNAP) for Temporary Assistance for Needy Families (TANF) and Companion State Supplemental Payment (SSP) Recipient(s)
 340:50-11-20 through 340:50-11-22 [AMENDED]
 340:50-11-25 [AMENDED]
 340:50 11-27 [AMENDED]
 Part 7. Replacement When Food Purchased with Food ~~Stamp~~ Benefits Is Destroyed [AMENDED]
 Part 9. Disaster Procedures and Reporting Requirements
 340:50-11-86 [AMENDED]
 340:50-11-88 [AMENDED]
 Part 11. Special Procedures for Joint Processing of ~~Food~~ Stamp Supplemental Nutrition Assistance Program and SSI Applicants
 340:50-11-105 [AMENDED]
 340:50-11-107 through 340:50-11-108 [AMENDED]
 Part 12. Categorically Eligible Households
 340:50-11-111 [AMENDED]
 Subchapter 13. Fair Hearings
 340:50-13-2 [AMENDED]
 Subchapter 15. Overpayments and Fraud
 Part 1. Overpayments
 340:50-15-1 [AMENDED]
 340:50-15-3 [AMENDED]
 340:50-15-5 through 340:50-15-6 [AMENDED]
(Reference APA WF 09-18 and 09-29)

GUBERNATORIAL APPROVAL:

March 26, 2010

[OAR Docket #10-506; filed 4-5-10]

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

[OAR Docket #10-507]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

340:60-1-3 [AMENDED]

(Reference APA WF 09-13)

GUBERNATORIAL APPROVAL:

March 26, 2010

[OAR Docket #10-507; filed 4-5-10]

**TITLE 435. STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
 CHAPTER 10. PHYSICIANS AND SURGEONS**

[OAR Docket #10-549]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 7. Regulation of Physician and Surgeon Practice

435:10-7-2. Use of Board certification [AMENDED]

GUBERNATORIAL APPROVAL:

March 30, 2010

[OAR Docket #10-549; filed 4-8-10]

**TITLE 435. STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
 CHAPTER 15. PHYSICIAN ASSISTANTS**

[OAR Docket #10-551]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 3. Licensure of Physician Assistants

435:15-3-18. License renewal period; reinstatement [AMENDED]

Gubernatorial Approvals

GUBERNATORIAL APPROVAL:

March 30, 2010

[OAR Docket #10-551; filed 4-8-10]

**TITLE 435. STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION
CHAPTER 40. REGISTERED
ELECTROLOGISTS**

[OAR Docket #10-552]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

435:40-1-5. Academic requirements for examination and licensure [AMENDED]

GUBERNATORIAL APPROVAL:

March 30, 2010

[OAR Docket #10-552; filed 4-8-10]

**TITLE 435. STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION
CHAPTER 45. RESPIRATORY CARE
PRACTITIONER**

[OAR Docket #10-553]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 5. Regulation of Practice

435:45-5-1. Continuing education [AMENDED]

GUBERNATORIAL APPROVAL:

March 30, 2010

[OAR Docket #10-553; filed 4-8-10]

**TITLE 485. OKLAHOMA BOARD OF
NURSING
CHAPTER 1. ADMINISTRATION**

[OAR Docket #10-582]

RULEMAKING ACTION:

Gubernatorial Approval of Permanent Rules

RULES:

485:1-1-1. [AMENDED]

485:1-1-2. [AMENDED]

485:1-1-4. [AMENDED]

485:1-1-5. [AMENDED]

GUBERNATORIAL APPROVAL:

February 15, 2010

[OAR Docket #10-582; filed 4-9-10]

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

[OAR Docket #10-583]

RULEMAKING ACTION:

Gubernatorial Approval of Permanent Rules

RULES:

Subchapter 1. General Provisions

485:10-1-2. [AMENDED]

Subchapter 5. Minimum Standards for Approved Nursing Education Programs

485:10-5-8. [AMENDED]

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

485:10-7-2. [AMENDED]

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

485:10-9-2. [AMENDED]

Subchapter 10. Advanced Unlicensed Assistive Personnel

485:10-10-8. [AMENDED]

485:10-10-8.1. [AMENDED]

Subchapter 11. Disciplinary Action

485:10-11-2. [AMENDED]

Subchapter 13. Requirements for Employment

485:10-13-1. [AMENDED]

Subchapter 19. Peer Assistance Program

485:10-19-4. [AMENDED]

485:10-19-5. [AMENDED]

485:10-19-8. [AMENDED]

GUBERNATORIAL APPROVAL:

February 15, 2010

[OAR Docket #10-583; filed 4-9-10]

**TITLE 610. STATE REGENTS FOR HIGHER
EDUCATION
CHAPTER 15. EDUCATIONAL OUTREACH**

[OAR Docket #10-521]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. Use of Towers, Facilities and Communications Services

610:1-15-1 [AMENDED]

610:1-15-2 [AMENDED]

610:1-15-3 [AMENDED]
GUBERNATORIAL APPROVAL:
March 5, 2010

[OAR Docket #10-521; filed 4-5-10]

**TITLE 610. STATE REGENTS FOR HIGHER
EDUCATION
CHAPTER 20. FISCAL AFFAIRS**

[OAR Docket #10-522]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. Regents' Endowment Fund Program
610:20-1-3 [AMENDED]
610:20-1-4 [AMENDED]

GUBERNATORIAL APPROVAL:

March 5, 2010

[OAR Docket #10-522; filed 4-5-10]

**TITLE 610. STATE REGENTS FOR HIGHER
EDUCATION
CHAPTER 25. STUDENT FINANCIAL AID
AND SCHOLARSHIPS**

[OAR Docket #10-523]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 23. Oklahoma Higher Learning Access Program
610:25-23-1 [AMENDED]
610:25-23-2 [AMENDED]
610:25-23-5 [AMENDED]
610:25-23-7 [AMENDED]
Subchapter 33. Regional University Baccalaureate Scholarship Program
610:25-33-6 [AMENDED]

GUBERNATORIAL APPROVAL:

March 5, 2010

[OAR Docket #10-523; filed 4-5-10]

**TITLE 612. STATE DEPARTMENT OF
REHABILITATION SERVICES
CHAPTER 1. ADMINISTRATIVE
OPERATIONS**

[OAR Docket #10-489]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 3. Administrative Components of the Department
612:1-3-2. The Director of Rehabilitation Services [AMENDED]
612:1-3-2.1. The ~~Deputy Director~~ Chief of Staff of Rehabilitation Services [AMENDED]
612:1-3-3. The Division Administrators/School Superintendents [AMENDED]
612:1-3-8.1. Executive officers [AMENDED]
612:1-3-10. Final signature authority [AMENDED]
Subchapter 5. Program Divisions Within the Department
612:1-5-4.2. Financial Services Division (FSD) [NEW]
Subchapter 17. Availability of Information, Scope and Description of Open Meetings
612:1-17-1. Access to DRS records [AMENDED]

GUBERNATORIAL APPROVAL:

March 25, 2010

[OAR Docket #10-489; filed 4-2-10]

**TITLE 612. STATE DEPARTMENT OF
REHABILITATION SERVICES
CHAPTER 3. MANAGEMENT SERVICES
DIVISION**

[OAR Docket #10-490]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions
612:3-1-3. Functions of the division [AMENDED]
Subchapter 3. Human Resources Unit
Part 3. Human Resources Management Section - Personnel Programs
612:3-3-20. Department of Rehabilitation Services recruitment and selection plan [AMENDED]
Subchapter 5. Policy Development and Program Standards
Part 3. Policy Development
612:3-5-12. Policy Development [AMENDED]
612:3-5-13. Drafting of new or revised policy [AMENDED]
Part 5. Program Standards
612:3-5-30. Vocational Rehabilitation and Visual Services compliance reviews [NEW]

Gubernatorial Approvals

GUBERNATORIAL APPROVAL:

March 25, 2010

[OAR Docket #10-490; filed 4-2-10]

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TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES CHAPTER 5. FINANCIAL SERVICES DIVISION

[OAR Docket #10-491]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions [NEW]

612:5-1-1. Purpose for Financial Policy [NEW]

612:5-1-2. Mission of the Financial Services Division
[NEW]

Subchapter 3. Regulatory Structures [RESERVED]

Subchapter 5. Agency Encumbrances [RESERVED]

Subchapter 7. Agency Expenditures [RESERVED]

Subchapter 9. Agency Budget Activity [RESERVED]

Subchapter 11. Special Accounts [RESERVED]

Subchapter 13. Financial Services Miscellaneous
[RESERVED]

GUBERNATORIAL APPROVAL:

March 25, 2010

[OAR Docket #10-491; filed 4-2-10]

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TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES CHAPTER 10. VOCATIONAL REHABILITATION AND VISUAL SERVICES

[OAR Docket #10-492]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions

612:10-1-7. Purchase of services and goods for individuals
with disabilities [AMENDED]

612:10-1-10. CARF - Vendors [NEW]

Subchapter 3. Client Participation in Cost of Services

612:10-3-5. Basic living requirements [AMENDED]

Subchapter 7. Vocational Rehabilitation and Visual
Services

Part 1. Scope of Vocational Rehabilitation and Visual
Services

612:10-7-1. Overview of Vocational Rehabilitation and
Visual Services [AMENDED]

612:10-7-2. Field Office responsibilities [AMENDED]

612:10-7-3. Client responsibilities [AMENDED]

612:10-7-6. Assessment for determining eligibility
[AMENDED]

Part 3. Case Processing Requirements

612:10-7-27. Career planning center services [REVOKED]

612:10-7-28. Vocational evaluation referrals [REVOKED]

612:10-7-29. Vocational evaluation referral process
[REVOKED]

612:10-7-30. Supportive services at career planning centers
[REVOKED]

612:10-7-32. Production standards [REVOKED]

612:10-7-33. Supervisory caseload reviews [REVOKED]

612:10-7-33.1. Quality Assurance caseload reviews
[REVOKED]

Part 5. Case Status and Classification System

612:10-7-47. Application Status [AMENDED]

612:10-7-49. Closed - Not Accepted for Services
[AMENDED]

612:10-7-62. Post-Employment services [AMENDED]

Part 9. Actions Requiring Review and Approval

612:10-7-87. Actions requiring supervisor's approval
[AMENDED]

612:10-7-88. Actions requiring field coordinator's approval
[REVOKED]

Part 11. Physical and Mental Restoration Services

612:10-7-98. General guidelines for physical and mental
restoration services [AMENDED]

612:10-7-101. Convalescent care [REVOKED]

612:10-7-102. Dental services [AMENDED]

612:10-7-103. Dialysis or treatment of end-stage renal
disease [AMENDED]

612:10-7-104. Drugs and supplies [AMENDED]

612:10-7-105. Hearing aids [AMENDED]

612:10-7-106. Hospitalization [AMENDED]

612:10-7-109. Low vision services [AMENDED]

612:10-7-111. Medical services for individuals under age
21 [REVOKED]

612:10-7-112. Nursing services [AMENDED]

612:10-7-117. Psychiatric and psychological treatment
[AMENDED]

Part 13. Supportive Services

612:10-7-130. Maintenance. [AMENDED]

612:10-7-131. Transportation [AMENDED]

Part 15. Training

612:10-7-142. General guidelines for training services
[AMENDED]

612:10-7-143. Coordination of training with other services
[REVOKED]

612:10-7-145. Counseling activities during training
program [AMENDED]

612:10-7-147. Special scholarships and training facilities
[REVOKED]

612:10-7-150. Continued eligibility for college or
university training [AMENDED]

612:10-7-151. Duration of college and university training
[AMENDED]

- 612:10-7-152. Payment of tuition and fees at colleges and universities [AMENDED]
- 612:10-7-153. Textbook allowance for college and university students [AMENDED]
- 612:10-7-154. Allowance for durable training supplies for college and university students [REVOKED]
- 612:10-7-157. Out-of-state training [AMENDED]
- 612:10-7-159. Privately owned business and trade schools [AMENDED]
- 612:10-7-161. Public vocational schools [AMENDED]
- 612:10-7-162. Supplies and training tools for business, vocational and trade schools [AMENDED]
- 612:10-7-163. On-the-job training [AMENDED]
- 612:10-7-164. Personal and work adjustment training [AMENDED]
- 612:10-7-168. Duties of home counselor [REVOKED]
- 612:10-7-169. Duties of counselors who supervise clients in training facilities [REVOKED]
- Part 21. Purchase of Equipment, Occupational Licenses and Certificates
- 612:10-7-220. Vehicle modification services [AMENDED]
- Part 23. Self-employment Programs and Other Services
- 612:10-7-230. Self-employment programs [AMENDED]
- 612:10-7-230.1. Definitions [REVOKED]
- 612:10-7-230.2. Self-Employment Guidelines [AMENDED]
- 612:10-7-230.3. Self-Employment/Business Plans [AMENDED]
- 612:10-7-230.4. Agency financial contribution to self-employment/purchasing [AMENDED]
- 612:10-7-230.5. DRS Monitoring [AMENDED]

GUBERNATORIAL APPROVAL:
March 25, 2010

[OAR Docket #10-492; filed 4-2-10]

**TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES
CHAPTER 20. SPECIAL SCHOOLS**

[OAR Docket #10-493]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 2. Contracted Instructional Personnel
- 612:20-2-11. Admonishment [AMENDED]
- 612:20-2-14. Immediate suspension of a teacher [AMENDED]
- 612:20-2-16. Administrators; suspension [AMENDED]
- 612:20-2-17. Full-time administrators; Appeal of dismissal or nonreemployment [AMENDED]

GUBERNATORIAL APPROVAL:

March 25, 2010

[OAR Docket #10-493; filed 4-2-10]

**TITLE 730. DEPARTMENT OF TRANSPORTATION
CHAPTER 30. HIGHWAY DESIGN**

[OAR Docket #10-532]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 9. Permitting of Oversize, Overweight and Special Combination Vehicles
- 730:30-9-16 [NEW]
- Appendix B. Minimum Axles, Axle Spacing and Inner Bridge Dimensions [REVOKED]
- Appendix E. Oklahoma Department of Transportation Weight Supplement Sheet for Annual Envelop Permit Not to Exceed 120,000 [NEW]

GUBERNATORIAL APPROVAL:

March 25, 2010

[OAR Docket #10-532; filed 4-6-10]

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

[OAR Docket #10-515]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 1. General Provisions
- 785:5-1-6. Stream water permit application and administration fees [AMENDED]
- 785:5-1-9. Dam safety and inspection fees [AMENDED]
- 785:5-1-10. Groundwater application and administration fees [AMENDED]
- 785:5-1-11. Well driller and pump installer licensing fees [AMENDED]
- 785:5-1-14. Stream water and groundwater petition fees [AMENDED]

GUBERNATORIAL APPROVAL:

February 26, 2010

[OAR Docket #10-515; filed 4-5-10]

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

[OAR Docket #10-516]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions

785:20-1-6. Who should file an application [AMENDED]

Subchapter 3. Application Requirements and Processing

785:20-3-2. General application requirements
[AMENDED]

Appendix A. Application for a Permit to Use Surface or
Stream Water [REVOKED]

Appendix A. Application for a Permit to Use Surface or
Stream Water [NEW]

GUBERNATORIAL APPROVAL:

February 26, 2010

[OAR Docket #10-516; filed 4-5-10]

**TITLE 785. OKLAHOMA WATER
RESOURCES BOARD
CHAPTER 25. DAMS AND RESERVOIRS**

[OAR Docket #10-517]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions

785:25-1-2. Definitions [AMENDED]

785:25-1-4. Variances and waivers [AMENDED]

Subchapter 3. Responsibility, Classification and Design
Standards

785:25-3-3. Classification of size and hazard potential
[AMENDED]

785:25-3-4. Dams considered unsafe and a menace to life
and property [AMENDED]

785:25-3-5. Minimum design standards (other than
spillway) [AMENDED]

785:25-3-10. Prohibited vegetation and erosion
[AMENDED]

Subchapter 5. Applications and Approval of Construction

785:25-5-3. Content of plans and specifications
[AMENDED]

785:25-5-5. Notice of application [AMENDED]

785:25-5-6. Affidavit of notice publication and ~~mailing~~
[AMENDED]

785:25-5-7. Protest and public comment [AMENDED]

Subchapter 7. Post Approval Actions

785:25-7-5. Changes to plans and specifications after
approval [AMENDED]

785:25-7-7. ~~Warning and evacuation~~ Emergency action
plans [AMENDED]

Subchapter 9. Actions after Construction

785:25-9-1. ~~Inspections~~ Inspection of dams [AMENDED]

785:25-9-9. Breach analysis for existing dams [NEW]

785:25-9-10. Reclassification of the hazard potential class
[NEW]

785:25-9-11. Upgrading dams due to downstream
development [NEW]

GUBERNATORIAL APPROVAL:

February 26, 2010

[OAR Docket #10-517; filed 4-5-10]

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

[OAR Docket #10-518]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions

785:30-1-4. Requirement for water right [AMENDED]

Subchapter 3. Permit Application Requirements and
Processing

785:30-3-6. Well spacing [AMENDED]

Appendix A. Application for a Permit to Use Groundwater
[REVOKED]

Appendix A. Application for a Permit to Use Groundwater
[NEW]

GUBERNATORIAL APPROVAL:

February 26, 2010

[OAR Docket #10-518; filed 4-5-10]

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

[OAR Docket #10-519]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions

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

Subchapter 3. Licensing and Certifications

785:35-3-2. Expiration and renewal of licenses and
certifications [AMENDED]

Subchapter 7. Minimum Standards for Construction of
Wells

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

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

Subchapter 11. Plugging and Capping Requirements for Wells and Test Holes

785:35-11-2. Plugging requirements for site assessment observation wells, monitoring wells and geotechnical borings [AMENDED]

GUBERNATORIAL APPROVAL:

February 26, 2010

[OAR Docket #10-519; filed 4-5-10]

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

[OAR Docket #10-520]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 8. Rural Economic Action Plan (REAP) Grant Program Requirements and Procedures

785:50-8-6. Disbursement of funds [AMENDED]

Subchapter 9. Clean Water State Revolving Fund Regulations

Part 1. General Provisions

785:50-9-9. Definitions [AMENDED]

Part 3. General Program Requirements

785:50-9-23. Clean Water SRF Project Priority System [AMENDED]

785:50-9-35. Loan closing [AMENDED]

785:50-9-45. Compliance with federal authorities [AMENDED]

Part 7. SRF Environmental Review Process

785:50-9-60. Requirement of environmental review [AMENDED]

785:50-9-61. Environmental information required by the Board [AMENDED]

785:50-9-62. Environmental review by the Board [AMENDED]

GUBERNATORIAL APPROVAL:

February 26, 2010

[OAR Docket #10-520; filed 4-5-10]

Withdrawn Rules

An agency may withdraw proposed PERMANENT rules prior to final adoption (approval by Governor/Legislature) by notifying the Governor and the Legislature and by publishing a notice in the *Register* of such a withdrawal.

An agency may withdraw proposed EMERGENCY rules prior to approval/disapproval by the Governor by notifying the Governor, the Legislature, and the Office of Administrative Rules. The withdrawal notice is not published in the *Register*, however, unless the agency published a Notice of Rulemaking Intent in the *Register* before adopting the EMERGENCY rules.

For additional information on withdrawal of proposed rules, see 75 O.S., Section 308(F) and 253(K) and OAC 655:10-7-33.

**TITLE 435. STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION
CHAPTER 10. PHYSICIANS AND
SURGEONS**

[OAR Docket #10-550]

RULEMAKING ACTION:

Withdrawal of PERMANENT rulemaking

RULES:

Subchapter 7. Regulation of Physician and Surgeon
Practice

435:10-7-2. Use of Board certification [AMENDED]

DATES:

Adoption:

March 11, 2010

Submitted to Governor:

March 15, 2010

Submitted to House:

March 15, 2010

Submitted to Senate:

March 15, 2010

Gubernatorial approval:

March 30, 2010

Withdrawn:

April 6, 2010

[OAR Docket #10-550; filed 4-8-10]

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 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 2. FEES

[OAR Docket #10-536]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Fee Schedules

35:2-3-2 [AMENDED]

35:2-3-2.2 [AMENDED]

35:2-3-2.3 [AMENDED]

35:2-3-2.4 [AMENDED]

35:2-3-2.5 [AMENDED]

35:2-3-2.7 [AMENDED]

AUTHORITY:

Oklahoma State Board of Agriculture; 2 O.S. §§ 2-4(20) and 14-83; Article 6, Section 31, Constitution of the State of Oklahoma

DATES:

Comment period:

December 1, 2009 through January 7, 2010

Public hearing:

January 7, 2010

Adoption:

January 20, 2010

Submitted to Governor:

January 25, 2010

Submitted to House:

January 25, 2010

Submitted to Senate:

January 25, 2010

Gubernatorial approval:

February 4, 2010

Legislative approval:

Failure of the Legislature to disapprove the rules resulted in approval on March 24, 2010

Final adoption:

March 24, 2010

Effective:

July 1, 2010

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

The proposed rules amend certain fees contained in Subchapter 3 pertaining to requests for rush sampling, feed and fertilizer, meat chemistry, microbiological, pesticide, and seed samples. These rules allow the Oklahoma Department of Agriculture, Food, and Forestry's Laboratory Services Division to recoup some of the costs associated with conducting the specific tests addressed by the amendments. In some cases, the fees are reduced, while in others, the fees are increased.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry (405) 522-4576

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 JULY 1, 2010:

SUBCHAPTER 3. FEE SCHEDULES

35:2-3-2. Schedules of laboratory fees

(a) The following schedules of laboratory testing fees shall apply to all samples submitted to the Oklahoma Department of Agriculture, Food, and Forestry Laboratory Services Division, unless otherwise stated.

(b) All listed fees are for standard analysis time according to the methods utilized and the workload of the Laboratory Services Division. Any request to rush the analysis of a sample shall be subject to a fifty percent (50%) surcharge.

(c) Samples submitted by or services provided to nonresident persons shall be billed at twice the listed fee.

(ed) Any listed fee may be waived if deemed necessary by the Laboratory Services Division Director.

(de) Fees may be discounted or waived pursuant to a contract for a high volume of samples as approved by the Board.

(ef) The following administrative fees shall apply to all types of testing:

- (1) Extra copies of official reports - \$1.00 per page.
- (2) Results delivered by facsimile - \$1.00 per page.
- (3) Complete analytical data packets with reports - \$50.00 per invoice.
- (4) Unlisted tests, special - \$50.00 per hour.

35:2-3-2.2. Schedule of feed and fertilizer testing fees

(a) Feeds and grains testing fees.

- (1) Proximate analysis:
 - (A) Ash - \$5.00.
 - (B) Fat, dry pet foods (Mojonnier) - \$25.00.
 - (C) Fat, all feeds (Soxtec) - \$15.00.
 - (D) Fiber, acid detergent (ADF) - \$8.50.
 - (E) Fiber, crude - \$10.00.
 - (F) Moisture - \$5.00.
 - (G) Non-protein nitrogen - \$15.00.
 - (H) Protein - ~~\$10.00~~ - (\$20.00).

(2) Other feed analysis:

- (A) Aflatoxins - \$35.00.
- (B) Fumonisin - \$35.00.

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- (C) Salt, from chloride - \$19.00.
- (D) Salt, from sodium - ~~\$16.00.~~ (\$20.00).
- (E) Sulfur - \$18.00.
- (F) Sugar, total as invert - \$50.00.
- (G) Vitamin A - \$60.00.
- (3) Drugs in feeds:
 - (A) Amprolium - \$50.00.
 - (B) Chlortetracycline - \$50.00.
 - (C) Decoquinatate - \$65.00.
 - (D) Lasalocid - \$65.00.
 - (E) Oxytetracycline - \$50.00.
 - (F) Sulfamethazine - \$65.00.
 - (G) Sulfathiazole - \$65.00.
 - (H) Tylosin - \$65.00.
- (b) Fertilizer testing fees.
 - (1) Major nutrients:
 - (A) Total Nitrogen - \$20.00.
 - (B) Available ~~Phosphorus~~ Phosphate - \$20.00.
 - (C) Soluble Potash - \$20.00.
 - (2) Micro nutrients: Total Sulfur - \$105.00.
 - (A) ~~Total Sulphur~~ - ~~\$35.00.~~
 - ~~(B)~~ Combined Sulfur - \$30.00.
 - ~~(C)~~ Free ~~Sulphur~~Sulfur - \$75.00.
- (c) Lime analysis, sieve, and effective calcium carbonate equivalent (ECCE) - \$40.00.
 - (1) Calcium in Lime - ~~\$10.00.~~ \$20.00.
 - (2) Magnesium in Lime - ~~\$10.00~~ \$20.00.
- (d) Elemental analysis testing fees by atomic absorption (AA) or inductively coupled plasma (ICP) spectrometry, each element - \$20.00.

35:2-3-2.3. Schedule of meat chemistry testing fees

- (a) Cereal (Starch Qualitative) - \$20.00.
- (b) Corn syrup solids - \$32.00.
- (c) Fat, total - \$30.00.
- (d) Maximum internal temperature - \$10.00.
- (e) Non-fat dry milk - \$32.00.
- (f) Phosphate - \$20.00.
- (g) Protein, total - ~~\$25.00.~~ \$20.00.
- (h) Salt - \$20.00.
- (i) Sodium nitrite, quantitative - \$20.00.
- (j) Sodium sulfite, qualitative - \$9.00.
- ~~(k)~~ Soy protein - \$30.00.
- ~~(l)~~ Water, total - \$13.00.

35:2-3-2.4. Schedule of dairy, food, water, and microbiological testing fees

- (a) Aerobic plate count - \$12.00.
- (b) Bacillus cereus, confirmed - \$61.00.
- (c) Bacillus cereus, presumptive - \$14.00.
- (d) Campylobacter - \$25.00.
- (e) Clostridium perfringens - \$20.00.
- (f) Coliform (PA or MF) - \$18.00.
- (g) Confirmed membrane filter (MF), lauryl sulfate tryptose (LST) and brilliant green bile (BGB) - ~~\$40.00.~~ \$18.00.
- (h) E. coli - ~~\$25.00.~~ \$40.00.
- (i) E. coli O157 - ~~\$30.00.~~ \$40.00.

- (j) Enterococcus - ~~\$25.00.~~ \$40.00.
- (k) Fecal coliform, membrane filter (MF), or most probable number (MPN) - ~~\$10.00.~~ \$18.00.
- (l) Filth and adulteration of foods, gross examination - \$10.00.
- (m) Gram stain - \$10.00.
- (n) Listeria - ~~\$30.00.~~ \$40.00.
- (o) pH food products - \$10.00.
- (p) Plate count, coliform - \$12.00.
- (q) Residual bacteria count - \$12.00.
- (r) Residual coliform count - \$12.00.
- (s) Ribotyping, individual bacteria - \$105.00.
- (t) Salmonella - \$40.00.
- (u) Shigella - ~~\$25.00.~~ \$40.00.
- (v) Staphylococcus - ~~\$25.00.~~ \$40.00.
- (w) Staphylococcus, confirmation of coagulase positive (+) - \$10.00.
- (x) Swab or utensil count - \$12.00.
- (y) Thermometer check - \$15.00.
- (z) Water activity - 30.00.
- (aa) Yeast and mold count - \$18.00.
- (bb) Antibiotics in dairy products (non-permitted dairies) - \$15.00.
- (cc) Sulfa and tetracycline drugs in milk - \$20.00.
- (dd) Fat (percent) in milk and milk products (raw) - \$6.00.
- (ee) Direct microscopic somatic cell count - ~~\$8.00.~~ \$10.00.
- (ff) Electronic somatic cell count - ~~\$8.00.~~ \$10.00.
- (gg) Added water in milk - \$12.00.
- (hh) Fat, protein, and lactose (pasteurized milk and retail products) - \$6.00.
- (ii) Bacterial DNA isolation and enrichment (Applied Biosystems PCR and Pathatrix for E. coli, Listeria, and Salmonella (not pooled samples) - \$30.00.
- (jj) Bacterial DNA isolation and enrichment (Applied Biosystems PCR and Pathatrix for E. coli, Listeria, Salmonella (pooled samples, twenty (20) or more) - \$20.00.
- (kk) Bacterial DNA identification (Applied Biosystems PCR and Qiacube PCR-prep) for E. coli, Listeria, and Salmonella - \$20.00.

35:2-3-2.5. Schedule of pesticide testing fees

- (a) Residue analyses:
 - (1) ~~In soils or waters - \$160.00.~~ Water samples:
 - (A) Organochloride/organophosphate/organonitrogen analysis - \$200.00.
 - (B) Herbicide analysis - \$250.00.
 - (C) Glyphosate analysis - \$325.00.
 - (D) Unknown/other - \$375.00.
 - (2) ~~In other matrices - \$240.00.~~ Soil samples:
 - (A) Organochloride/organophosphate/organonitrogen analysis - \$200.00.
 - (B) Herbicide analysis - \$300.00.
 - (C) Glyphosate analysis - \$350.00.
 - (D) Unknown/other - \$375.00.
 - (3) Vegetation samples:
 - (A) Organochloride/organophosphate/organonitrogen analysis - \$250.00.
 - (B) Herbicide analysis - \$300.00.

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- (C) Glyphosate analysis - \$375.00.
- (D) Unknown/other - \$400.00.
- (4) Organic food program or food samples:
 - (A) Organochloride/organophosphate/organonitrogen analysis - \$275.00.
 - (B) Herbicide analysis - \$325.00.
 - (C) Glyphosate analysis - \$375.00.
 - (D) Unknown/other - \$400.00.
- (5) Surface/Swab samples:
 - (A) Organochloride/organophosphate/organonitrogen analysis - \$250.00.
 - (B) Herbicide analysis - \$325.00.
 - (C) Glyphosate analysis - \$400.00.
 - (D) Unknown/other - \$400.00.
- (6) Air Samples:
 - (A) Organochloride/organophosphate/organonitrogen analysis - \$300.00.
 - (B) Herbicide analysis - \$350.00.
 - (C) Glyphosate analysis - \$400.00.
 - (D) Unknown/other - \$400.00.
- (7) Animal Tissue:
 - (A) Organochloride/organophosphate/organonitrogen analysis - \$375.00.
 - (B) Herbicide analysis - \$375.00.
 - (C) Glyphosate analysis - \$400.00.
 - (D) Unknown/other - \$400.00.
- (8) Other matrices not listed above:
 - (A) Organochloride/organophosphate/organonitrogen analysis - \$375.00.
 - (B) Herbicide analysis - \$400.00.
 - (C) Glyphosate analysis - \$400.00.
 - (D) Unknown/other - \$400.00.
- (b) Formulations or tank mixes:
 - (1) ~~Up to two~~ Single components - ~~\$90.00.~~ \$100.00.
 - (2) ~~Three or more~~ Two components - ~~\$160.00.~~ \$125.00.
 - (3) Three or more components - \$200.00.
 - (4) Aerosols - \$160.00. \$225.00.
 - (4~~5~~) Baits - \$180.00. \$250.00.
 - (5~~6~~) Unknowns - \$180.00. \$250.00.

35:2-3-2.7. Schedule of seed testing fees

- (a) Germination all seeds, each component - \$12.00.
- (b) Purity other than grasses, clovers, mixtures, and unprocessed seed - \$13.00.
- (c) Purity for grasses, clovers, mixtures, and unprocessed seed - \$20.00 per hour.
- (d) Tetrazolium (TZ) testing - \$20.00.
- (e) Stress/vigor test/accelerated aging - \$12.00.
- (f) Noxious weed check - \$15.00 per hour.
- (g) Seed count - \$4.00.
- (h) Test weight - \$2.00.

[OAR Docket #10-536; filed 4-7-10]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions
35:10-1-3 [AMENDED]

AUTHORITY:

Oklahoma State Board of Agriculture; 2 O.S. §§ 2-4, 14-31 et seq.; Article 6, Section 31, Constitution of the State of Oklahoma

DATES:

Comment period:

October 1, 2009 through November 2, 2009

Public hearing:

November 2, 2009

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November 18, 2009

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November 18, 2009

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December 18, 2009

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Failure of the Legislature to disapprove the rules resulted in approval on March 24, 2010

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March 24, 2010

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July 1, 2010

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

Incorporated standards:

National Institute of Standards and Technology (NIST), Handbook 44 (2010 Edition)

Incorporating rules:

35:10-1-3

Availability:

8:00 a.m. to 5:00 p.m., Monday through Friday at the Oklahoma Department of Agriculture, 2800 North Lincoln Boulevard, Oklahoma City, Oklahoma, 405-522-4576

ANALYSIS:

The proposed rules update the dates of NIST Handbook incorporations by reference and establish additional procedures for checking prices, net contents of goods, and packaging and labeling of products.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry (405) 522-4576

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 JULY 1, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

35:10-1-3. Handbook and publication editions

References to a Handbook or publication in these rules shall mean the following edition of the National Institute of

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Standards and Technology (NIST), unless a different reference is made in the text of the rule:

- (1) Handbook 44 "Specifications, Tolerances and Other Technical Requirements for Commercial Weighing & Measuring Devices" (2009 2010 Edition).
- (2) Handbook 130 "Uniform Laws and Regulations" (2009 Edition), excluding Section G "Uniform Engine Fuels and Automotive Lubricants Regulation."
- (3) Handbook 133 "Checking the Net Contents of Packaged Goods" (2005 Edition).
- (4) Handbook 105-1 "Specifications and Tolerances for Field Standard Weights" (1990 Edition).
- (5) Handbook 105-2 "Specifications and Tolerances for Field Standard Measuring Flasks" (1996 Edition).
- (6) Handbook 105-3 "Specifications and Tolerances for Graduated Neck Type Volumetric Field Standards" (2004 Edition).
- (7) Publication 14 (2009 Edition).
- (8) Publication 12 (1991 Edition).
- (9) Federal Grain Inspection Service Moisture Handbook (2006 Edition).

[OAR Docket #10-538; filed 4-7-10]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 13. FUEL ALCOHOL

[OAR Docket #10-539]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Chapter 13. Fuel Alcohol

35:13-1-1 [AMENDED]

35:13-1-2 [AMENDED]

AUTHORITY:

2 O.S. §§ 2-4, 2-18, 11-20 et seq.; Article 6, Section 31, Constitution of the State of Oklahoma

DATES:

Comment period:

September 1, 2009 through October 1, 2009

Public hearing:

October 1, 2009

Adoption:

October 21, 2009

Submitted to Governor:

October 23, 2009

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October 23, 2009

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October 23, 2009

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November 3, 2009

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Failure of the Legislature to disapprove the rules resulted in approval on March 24, 2010

Final adoption:

March 24, 2010

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July 1, 2010

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

Incorporated standards:

The Distilled Spirits for Fuel Use regulations found in Title 27 of the Code of Federal Regulations (CFR) (~~2006~~2009 Revision), Part 19.901 et seq., with exceptions.

Incorporating rules:

35:13-1-1 [AMENDED]

35:13-1-2 [AMENDED]

Availability:

8:00 a.m. to 5:00 p.m., Monday through Friday at the Oklahoma Department of Agriculture, Food, and Forestry, 2800 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4298, 405-522-4576

ANALYSIS:

The proposed rules incorporate the date for the most recent version of the Code of Federal Regulations.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry, (405) 522-4576

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 JULY 1, 2010:

35:13-1-1. Incorporation by reference of federal distilled spirits for fuel use regulations

The Distilled Spirits for Fuel Use regulations found in Title 27 of the Code of Federal Regulations (CFR) (~~2008~~ 2009 Revision), Part 19.901 et seq. for the United States Department of the Treasury, Alcohol and Tobacco Tax and Trade Bureau, as promulgated and amended in the Federal Register, are hereby adopted in their entirety with the exception of the deleted regulations specified in 35:13-1-2.

35:13-1-2. Deleted regulations

The following sections of the Code of Federal Regulations governing distilled spirits for fuel use of the United States Department of the Treasury, Alcohol and Tobacco Tax and Trade Bureau incorporated by reference under 35:13-1-1 are deleted and are not rules of the Oklahoma Department of Agriculture, Food, and Forestry: 27 CFR §§ 19.905, 19.906, 19.955, 19.956, 19.957, 19.958, and 19.959 (~~2008~~ 2009 Revision).

[OAR Docket #10-539; filed 4-7-10]

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

[OAR Docket #10-540]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 16. Contagious Equine Metritis

35:15-16-1 [AMENDED]

Subchapter 36. Scrapie

35:15-36-1 [AMENDED]

35:15-36-2 [AMENDED]

AUTHORITY:

State Board of Agriculture; 2 O.S. §§ 2-4, 6-2, 6-124, 6-131, and 6-152; Article 6, Section 31, Constitution of the State of Oklahoma

DATES:

Comment period:

September 1, 2009 through October 1, 2009

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SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

Incorporated standards:

Title 9 CFR 2009 Revision, Section 93-301

Title 9 CFR 2009 Revision, Part 79 et seq. with the exception of the following regulations: 79.6 and 79.7

Incorporating rules:

35:15-16-1

35:15-36-1

Availability:

8:00 a.m. to 5:00 p.m., Monday through Friday at the Oklahoma Department of Agriculture, Food, and Forestry, 2800 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4298.

ANALYSIS:

The proposed rules update the incorporation by reference of the Code of Federal Regulations for Contagious Equine Metritis and Scrapie.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry (405) 522-4576

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 JULY 1, 2010:

SUBCHAPTER 16. CONTAGIOUS EQUINE METRITIS

35:15-16-1. Incorporation by reference

(a) The contagious equine metritis regulation found in Title 9 of the Code of Federal Regulations (CFR) (~~2008~~ 2009 Revision), Section 93-301 for the United States Department of Agriculture (USDA) as promulgated and amended in the Federal Register, is hereby adopted in its entirety.

(b) All words and terms defined or used in the federal regulation incorporated by reference by the Department shall mean the state equivalent or counterpart to those words or terms.

SUBCHAPTER 36. SCRAPIE

35:15-36-1. Incorporation by reference of federal regulations

(a) The Scrapie in Sheep and Goats Regulations found in Title 9 of the Code of Federal Regulations (CFR) ~~2008~~ 2009 Revision, Part 79 et seq. for the United States Department of Agriculture (USDA) as promulgated and amended in the Federal Register, are hereby adopted in their entirety with the exception of the deleted regulations specified in 35:15-36-2.

(b) All words or terms defined or used in the Federal regulations incorporated by reference shall mean the state equivalent or counterpart to those words or terms.

35:15-36-2. Deleted regulations

The following sections of the Federal regulations governing scrapie in sheep and goats (9 CFR, Part 79 et seq.) (~~2008~~ 2009 Revision) of the USDA incorporated by reference under 35:15-36-1 are deleted and are not rules of the Oklahoma Department of Agriculture, Food, and Forestry: 79.6 and 79.7.

[OAR Docket #10-540; filed 4-7-10]

**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 30. CONSUMER PROTECTION**

[OAR Docket #10-537]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 17. Combined Pesticide
 - Part 1. Commercial and Non-Commercial Categories of Pesticide Application
 - 35:30-17-1.2 [NEW]
- Subchapter 25. Seed
 - 35:30-25-15 [NEW]
- Subchapter 27. Feed
 - Part 1. Commercial Feed
 - 30-30-27-11 [AMENDED]
- Subchapter 29. Fertilizer
 - Part 5. Licenses and Complaints
 - 35:30-29-51 [AMENDED]
- Subchapter 31. Lime
 - 35:30-31-4 [NEW]
- Subchapter 37. Nursery Stock Sales
 - 35:30-37-12 [NEW]
- Subchapter 38. Apiaries
 - 35:30-38-13 [NEW]

AUTHORITY:

Oklahoma State Board of Agriculture; 2 O.S. §§ 2-4, 3-31.1 et seq., 3-81 et seq., 3-100 et seq., 8-21 et seq., 8-41.1 et seq., 8-77.1 et seq., and 8-80.1 et seq.; Article 6, Section 31, Constitution of the State of Oklahoma

DATES:

Comment period:

December 1, 2009 through January 7, 2010

Public hearing:

January 7, 2010

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Submitted to Governor:

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February 16, 2010

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Failure of the Legislature to disapprove the rules resulted in approval on March 24, 2010

Final adoption:

March 24, 2010

Effective:

July 1, 2010

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

The proposed rules incorporate fees for these programs into the program rules. At this time, the fees are in the statute or are in Chapter 2 of the Department's rules. None of these rules result in fee increases or decreases. They are simply a copy of existing fees to ensure the public can view a program and know the fees associated with that program.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry (405) 522-4576

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 JULY 1, 2010:

SUBCHAPTER 17. COMBINED PESTICIDE

PART 1. COMMERCIAL AND NON-COMMERCIAL CATEGORIES OF PESTICIDE APPLICATION

35:30-17-1.2. Schedule of combined pesticide program fees

(a) The fees for issuance or renewal of pesticide applicators licenses shall be as follows:

(1) Commercial applicator - One Hundred Dollars (\$100.00) per category, Five Hundred Dollars (\$500.00) maximum for each location.

(2) Non-commercial applicator - Fifty Dollars (\$50.00) per category, Two Hundred Fifty Dollars (\$250.00) maximum for each location.

(3) Government agencies or their employees - No charge for commercial or non-commercial applicator.

(4) Duplicate issue - Ten Dollars (\$10.00) each.

(5) Private applicator - Twenty Dollars (\$20.00) each.

(6) Failure to remit a commercial or non-commercial applicator license renewal fee by the 1st day of January shall result in a penalty of twice the amount of the license renewal fee, and after the 1st day of February shall also result in a new examination being required.

(b) The issuance and annual registration fees for each pesticide and device label shall be as follows:

(1) Pesticide - One Hundred Sixty Dollars (\$160.00) each.

(2) Device - One Hundred Sixty Dollars (\$160.00) each.

(3) Failure to remit the registration fees for pesticides and devices by the 15th of the month following the month of expiration shall result in a penalty of twice the amount of the renewal fee.

(c) The annual permit fee for a restricted use pesticide dealer shall be Fifty Dollars (\$50.00) for each location. Failure to remit the permit fee by the 15th of the month following the month of expiration shall result in a penalty of twice the amount of the renewal fee.

(d) The annual permit fee for a non restricted use pesticide dealer shall be:

(1) Annual pesticide or device sales greater than \$5,000.00 - Fifty Dollars (\$50.00) for each location.

(2) Annual pesticide or device sales \$5,000.00 or less - Twenty Five Dollars (\$25.00) for each location.

(3) Failure to remit the permit fee by the 15th of the month following the month of expiration shall result in a penalty of twice the amount of the renewal fee.

(e) The fee for each written examination or practical conducted for the combined pesticide program shall be as follows:

(1) Written examination - Fifty Dollars (\$50.00).

(2) Practical conducted - Fifty Dollars (\$50.00).

(3) Government agencies or their employees - No charge.

(f) Applicator certification fees shall be as follows:

(1) Re-certification procedure - Fifty Dollars (\$50.00) for each.

(2) Reciprocal certification procedure - One Hundred Dollars (\$100.00) for each.

(3) Government agencies or their employees - No charge.

(g) Identification card fees shall be as follows:

(1) Service technician - Twenty Dollars (\$20.00) each.

(2) Certified applicator - No charge.

(3) Duplicate issue or transfers - Ten Dollars (\$10.00) each.

(h) The annual permit fee for pesticide producing facilities, including facilities that produce pesticidal devices, shall be One Hundred Dollars (\$100.00) for each location.

(1) All permits for pesticide producer establishments shall be issued for a period of one (1) year and shall be renewed annually.

(2) All permits shall expire on June 30 each year and may be renewed without penalty upon filing of a properly completed application not later than the fifteenth day of the month first following the date of expiration.

(3) If the application is not received by that date, a penalty of twice the amount of the renewal fee shall be charged for renewal of the permit.

(i) All fees and monies collected under this program shall be paid to the Oklahoma Department of Agriculture, Food, and Forestry.

SUBCHAPTER 25. SEED

35:30-25-15. Schedule of seed program fees

(a) The annual license fee shall be Twenty Five Dollars (\$25.00) for each retail seed dealer and One Hundred Dollars (\$100.00) for each retail-wholesale seed dealer. Each license shall expire on June 30 of each year.

(b) An inspection fee of eight cents (\$0.08) per hundred pounds shall be paid by every person responsible for labeling and distributing seed to a retail seed licensee in Oklahoma, or each retail seed licensee who processes and sells seed to the consumer on which the inspection fee has not been paid.

(1) A semi-annual affidavit, stating the number of pounds of seed sold for the preceding six (6) months, shall be filed no later than the last day of January and July and the inspection fee shall be paid upon filing of the affidavit.

(2) Failure to submit the semi-annual statement on time shall result in an inspection fee penalty of ten percent (10%) of the amount due or Ten Dollars (\$10.00), whichever is greater.

(c) If the State Board of Agriculture finds any deficient inspection fees due as a result of an audit of the records of any person subject to the provisions of Sections 8-21 through 8-28 of Title 2 of the Oklahoma Statutes, the Board shall assess a penalty fee of ten percent (10%), not to exceed Two Thousand Dollars (\$2,000.00) of the amount due, or One Hundred Dollars (\$100.00), whichever is greater. The audit penalty shall be added to the deficient inspection fees due and payment of the entire amount shall be made within thirty (30) calendar days of notice of the deficiency.

SUBCHAPTER 27. FEED

PART 1. COMMERCIAL FEED

35:30-27-11. License fee Schedule of feed program fees

(a) Each application to obtain a license to manufacture or distribute commercial feed products within the state shall be accompanied by a license fee of Twenty Dollars (\$20.00). License renewal applications received thirty (30) days after the due date shall be subject to a late filing fee of Fifty Dollars (\$50.00).

(b) An inspection fee of fifteen cents (\$0.15) per ton shall be paid on commercial feeds and/or feed ingredients. The minimum semi-annual inspection fee shall be Ten Dollars (\$10.00). Inspection fees which are due and have not been remitted to the Board within fifteen (15) days following the date due shall have a penalty fee of ten percent (10%) or Fifty Dollars (\$50.00) minimum added to the amount due when payment is finally made.

(c) If the Board finds any deficient inspection fees due, as a result of an audit of the records of any person subject to the provisions of the Oklahoma Commercial Feed Law, the Board shall assess a penalty fee of ten percent (10%) maximum not to exceed Two Thousand Dollars (\$2,000.00) of amount due,

or One Hundred Dollars (\$100.00), whichever is greater. The audit penalty shall be added to the deficient inspection fees due and payment made within thirty (30) days.

SUBCHAPTER 29. FERTILIZER

PART 5. LICENSES AND COMPLAINTS

35:30-29-51. Fertilizer license and schedule of fertilizer fees

(a) Any person engaged in the distribution or sale of fertilizer shall obtain a license.

(b) The Board shall not issue a fertilizer license to any bulk dry, liquid, or anhydrous ammonia facility unless the following are approved by the Board:

- (1) Completed fertilizer license application.
- (2) A completed fertilizer facility application package shall be submitted in a format approved by the Board.
- (3) Site inspection performed by the Board prior to construction.
- (4) Final construction of the facility.
- (5) Completion of all other conditions required by the Board.

(c) The Board shall not issue and may revoke any fertilizer registration if the Board determines:

- (1) The nutrient value of the product or substance has inadequate plant food content.
- (2) The registration is for the primary purpose of disposal of the product or substance.

(d) Fertilizer license renewal applications received thirty (30) or more days after the renewal date shall result in the Board charging a penalty equal and in addition to the cost of the license.

(e) Fees for the fertilizer program shall be as follows:

(1) The annual fee for persons operating a business engaged in the distribution or sale of a commercial fertilizer shall be Fifty Dollars (\$50.00) and expire on December 31 of each year.

(2) An inspection fee of sixty-five (\$0.65) cents per ton of which thirty cents (\$0.30) per ton shall be forwarded directly to a special Soil Fertility Research Account in the Plant and Soil Sciences Department of the Division of Agricultural Sciences and Natural Resources at Oklahoma State University for the sole purpose of conducting soil fertility research involving groundwater protection from plant food nutrients, Oklahoma State University shall present an annual report to the Agriculture Committees of the Legislature on the use of the special Soil Fertility Research Account Fund.

(3) Each registrant distributing commercial fertilizer in this state shall file with the Board not later than the last day of January and July of each year, a semiannual statement under oath, setting forth the number of net tons of commercial fertilizer distributed during the preceding three (3) calendar months. The inspection fee and tonnage report shall be due within thirty (30) days following the close of

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the filing period and upon return of the statement the licensee shall pay the inspection fee. If no fertilizer was sold or distributed in this state for the quarter, the registrant shall submit a statement reflecting that information and shall remit a minimum fee of Ten Dollars (\$10.00). If the inspection fee and tonnage report is not filed and the payment of inspection fee is not made within thirty (30) days after the end of the specified filing period, a collection fee of ten percent (10%) of the inspection fee due or a minimum Ten Dollars (\$10.00), shall be assessed and added to the amount due.

(4) If the Board finds any deficient inspection fees due as a result of an audit of the records of any person subject to the provisions of the Oklahoma Fertilizer Act, the Board shall assess a penalty fee of ten percent (10%) of the amount due, with a maximum not to exceed Two Thousand Dollars (\$2,000.00) or a minimum of One Hundred Dollars (\$100.00) whichever is greater. The audit penalty shall be added to the deficient inspection fees due and payment shall be made within thirty (30) days of notice of the deficiency.

(5) Annual registrations for specialty fertilizer products sold in packages of less than thirty (30) pounds shall pay a One-hundred Dollar (\$100.00) registration fee for each product. Specialty fertilizer product registrations shall expire on June 30 of each year. The penalty for failure to register any specialty fertilizer product shall be One-hundred Dollars (\$100.00) per product and shall be added to the registration fee and payment shall be made within thirty (30) days after receipt of notice.

SUBCHAPTER 31. LIME

35:30-31-4. Schedule of ag-lime program fees

(a) The annual vendors license fee shall be Twenty Five Dollars (\$25.00). Each license shall expire December 31 of each year.

(b) An inspection fee of ten cents (\$0.10) per ton shall be paid to the Board on all agricultural liming material sold or distributed for use within this state. If no lime was sold or distributed in this state for the semiannual period, manufacturers shall submit a statement reflecting that information and shall remit a minimum fee of Five Dollars (\$5.00).

(c) If the Board finds any deficient inspection fees due, as a result of an audit of the records of any person subject to the provisions of the Oklahoma Agricultural Liming Materials Act, the Board shall assess a penalty fee of ten percent (10%) maximum not to exceed Two Thousand Dollars (\$2,000.00) of amount due, or One Hundred Dollars (\$100.00), whichever is greater. The audit penalty shall be added to the deficient inspection fees due and payment made within thirty (30) days.

SUBCHAPTER 37. NURSERY STOCK SALES

35:30-37-12. Schedule of horticulture program fees

(a) The fee for each Federal Phytosanitary Certificate issued or renewed shall be as follows:

(1) Federal Phytosanitary Certificate PPQ Form 577

(A) If the aggregate commercial value of the product inspected for certification is \$1,250.00 or more - Fifty Dollars (\$50.00).

(B) If the aggregate commercial value of the product inspected for certification is less than \$1,250.00 - Twenty Five Dollars (\$25.00).

(2) Federal Phytosanitary Certificate, Processed Plant Products PPQ Form 578

(A) If the aggregate commercial value of the product inspected for certification is \$1,250.00 or more - Fifty Dollars (\$50.00).

(B) If the aggregate commercial value of the product inspected for certification is less than \$1,250.00 - Twenty Five Dollars (\$25.00).

(3) Federal Phytosanitary Certificate for Re-export PPQ Form 579.

(A) If the aggregate commercial value of the product inspected for certification is \$1,250.00 or more - Fifty Dollars (\$50.00).

(B) If the aggregate commercial value of the product inspected for certification is less than \$1,250.00 - Twenty Five Dollars (\$25.00).

(4) Ten Dollars (\$10.00) for the re-issuance of a Federal Phytosanitary Certificate.

(b) The fee for each State Phytosanitary Certificate issued or renewed shall be Twenty Dollars (\$20.00) except there shall be no charge for the issuance of a certificate required by the Japanese Beetle Harmonization Plan unless a treatment is monitored by an authorized agent of the Board.

(c) The fee for each grower, dealer, broker, and landscaper license issued or renewed and inspection conducted shall be as follows:

(1) Growers license - Twenty five Dollars (\$25.00) for each business location.

(2) Growers inspection fee - One Dollar (\$1.00) per acre and per 1000 square feet of greenhouse area inspected.

(3) Dealers, broker license and landscapers fees -Thirty eight Dollars (\$38.00) for each business location.

(4) Landscaper or Personal Use Only license fee - One Hundred Dollars (\$100.00) for each business location.

(5) No fee for shall be charged for a grower's license issued to any scientific, agricultural, or horticultural club, garden center, educational or eleemosynary institution, or any department or branch of the state or federal government:

(6) Failure to remit the license fee by the 15th of the month following the expiration month shall result in a penalty fee equal to the cost of the license.

(d) A fee of Twenty-Five Dollars (\$25.00) shall be charged for any requested inspection or certification and shall be payable at the time of inspection and includes inspections and certificates issued for transporting plants.

(e) All fees and monies collected under this program shall be paid to the Oklahoma Department of Agriculture, Food, and Forestry.

SUBCHAPTER 38. APIARIES

35:30-38-13. Apiary program fees

(a) The fee for any person registering pursuant to the Oklahoma Apiary Act shall be Ten Dollars (\$10.00).

(b) An entry permit fee of One Hundred Dollars (\$100.00) shall be charged for migratory beekeepers moving colonies of bees into this state.

(c) Any person requesting inspection of an apiary shall pay a fee based on the total number of hives listed on the certificate of inspection. The following inspection fees shall be charged at the time of inspection:

- (1) One to 25 hives: \$10.00.
- (2) 26 to 50 hives: \$25.00.
- (3) 51 to 100 hives: \$50.00.
- (4) 101 to 250 hives: \$75.00.
- (5) 251 to 500 hives: \$100.00.
- (6) 501 to 1,000 hives: \$200.00.
- (7) More than 1,000 hives: \$250.00.

(d) Any person requesting the Department to take samples for laboratory diagnosis shall be charged Twenty-five Dollars (\$25.00) for each sample. This charge shall not include the actual cost of diagnosis charged by the laboratory.

(e) All fees are due within thirty (30) days after samples are processed or the inspection is completed. Late payment of fees are subject to a penalty of ten percent (10%) of the amount due or Ten Dollars (\$10.00), whichever is greater.

[OAR Docket #10-537; filed 4-7-10]

**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 30. CONSUMER PROTECTION**

[OAR Docket #10-541]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 17. Combined Pesticide
Part 1. Commercial and Non-Commercial Categories of Pesticide Application
35:30-17-3. Categories of pesticide dealer permits [AMENDED]
35:30-17-3.1. ~~Pesticide~~Restricted use pesticide dealer permit required [AMENDED]
35:30-17-3.3 Non-restricted use pesticide dealer permit[REVOKED]

AUTHORITY:
2 O.S. §§ 2-4, 3-81 et seq.; Article 6, Section 31, Constitution of the State of Oklahoma

DATES:
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October 23, 2009

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Failure of the Legislature to disapprove the rules resulted in approval on March 24, 2010

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July 1, 2010

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 17. Combined Pesticide
Part 1. Commercial and Non-Commercial Categories of Pesticide Application

35:30-17-3. Categories of pesticide dealer permits [AMENDED]

35:30-17-3.1. ~~Pesticide~~Restricted use pesticide dealer permit required [AMENDED]

35:30-17-3.3 Non-restricted use pesticide dealer permit[REVOKED]

Gubernatorial approval:

June 23, 2009

Register publication:

26 Ok Reg 2807

Docket number:

09-1195

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

The proposed rules revoke the requirements for permitting of dealers who sell non restricted use pesticides. The permitting program began in 2007, however, during the launching of the program, the Department determined that several significant concerns had arisen among the public. A second rulemaking in 2008 attempted to correct the problems, however, the Department determined that the concerns could only be adequately addressed by revoking the non restricted use pesticide dealers permitting program. The Department previously revoked these rules through an emergency rulemaking.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry (405) 522-4576

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 JULY 1, 2010:

SUBCHAPTER 17. COMBINED PESTICIDE

PART 1. COMMERCIAL AND NON-COMMERCIAL CATEGORIES OF PESTICIDE APPLICATION

35:30-17-3. Categories of pesticide dealer permits

(a) A restricted use pesticide dealer permit includes the sale, offer for sale, or distribution within this state of any restricted use pesticide.

(b) ~~A non restricted use pesticide dealer permit includes the sale, offer for sale, or distribution within this state of any non-restricted use pesticide or device.~~

Permanent Final Adoptions

35:30-17-3.1. ~~Pesticide Restricted use pesticide dealer permit required~~

- (a) It shall be unlawful for any person to sell, offer for sale, or distribute within this state any restricted use pesticide without first obtaining a pesticide dealer's permit issued by the Board.
- (b) ~~A permit may be issued by the Board in any category of pesticide sales if the applicant qualifies under the provisions of this subarticle and the applicant is limited to the category of pesticide sales named on the permit. The Board may establish categories of pesticide sales as necessary.~~
- (c) The permit shall be issued only upon application on a form prescribed by the Board and the application shall contain information regarding the applicant's proposed operation and other information as specified by the Board.

35:30-17-3.3. ~~Non-restricted use pesticide dealer permit [REVOKED]~~

- (a) ~~Each business location engaged in the sale or distribution of non-restricted use pesticides or devices shall require a separate permit.~~
- (b) ~~The annual permit fee for a non-restricted use pesticide dealer permit shall be:~~
- ~~(1) Annual pesticide or device sales greater than \$5,000.00 Fifty Dollars (\$50.00) for each location.~~
 - ~~(2) Annual pesticide or device sales \$5,000.00 or less Twenty Five Dollars (\$25.00) for each location.~~
- (c) ~~A business that has a valid restricted use pesticide dealer permit shall not be required to purchase a non-restricted use pesticide dealer permit, but the business shall be considered to act as a non-restricted use pesticide dealer if the pesticides or devices are sold at the business.~~
- (d) ~~The Board may require a certified applicator to be present at any location where designated non-restricted use pesticide sales occur.~~
- (e) ~~Every non-restricted use pesticide dealer shall keep accurate records pertaining to non-restricted use pesticide or device purchases or sales, as required by the Board. The records shall be kept intact at the principal business location in this state for at least two (2) years after their date of expiration. Copies shall be furnished to any authorized agent of the Board at any time during the regular business hours of the dealer, immediately upon request in person, or within seven (7) working days of a written request, in summary form, by mail, fax, email, web site, or any other electronic media customarily used.~~
- (f) ~~It shall be the duty of the Board to audit the maintenance of records as necessary to carry out the provisions of the Oklahoma Agricultural Code.~~

[OAR Docket #10-541; filed 4-7-10]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 30. CONSUMER PROTECTION

[OAR Docket #10-543]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 17. Combined Pesticide
Part 6. Pesticidal Product Producing Establishments
35:30-17-13 [AMENDED]
Part 21. Standard for disposal of pesticide and pesticide containers
35:30-17-89.1 [AMENDED]

AUTHORITY:

Oklahoma State Board of Agriculture; 2 O.S. §§ 2-4, 3-81 et seq.; Article 6, Section 31, Constitution of the State of Oklahoma

DATES:

Comment period:

September 1, 2009 through October 1, 2009

Public hearing:

October 1, 2009

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November 3, 2009

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Failure of the Legislature to disapprove the rules resulted in approval on March 24, 2010

Final adoption:

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Effective:

July 1, 2010

Incorporating rules:

35:30-17-13
35:30-17-89.1

Availability:

8:00 a.m. to 5:00 p.m., Monday through Friday at the Oklahoma Department of Agriculture, Food, and Forestry, 2800 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4298, 405-522-4576

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

Title 40 CFR 2009 Revision, Part 167 et seq. and Part 169 et seq. with the exception of 40 CFR § 167.90; Part 156.140 et seq. and Part 165 et seq.

ANALYSIS:

The proposed rules incorporate the date for the most recent version of the Code of Federal Regulations.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry (405) 522-4576

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 JULY 1, 2010:

SUBCHAPTER 17. COMBINED PESTICIDE

PART 6. PESTICIDAL PRODUCT PRODUCING ESTABLISHMENTS

35:30-17-13. Incorporation by reference of federal pesticide producing establishment regulations

(a) The Registration of Pesticide and Active Ingredient Producing Establishments, Submission of Pesticide Reports and Books and Records of Pesticide Production and Distribution Regulations found in Title 40 of the Code of Federal Regulations (CFR) ~~2008~~ 2009 Revision, Part 167 et seq. and Part 169 et seq. for the United States Environmental Protection Agency (EPA) as promulgated and amended in the Federal Register, are hereby adopted in their entirety with the exception of 40 CFR § 167.90.

(b) All words or terms defined or used in the Federal regulations incorporated by reference shall mean the state equivalent or counterpart to those words or terms.

PART 21. STANDARDS FOR DISPOSAL OF PESTICIDE AND PESTICIDE CONTAINERS

35:30-17-89.1. Incorporation by reference of federal pesticide management and disposal regulations

(a) The Labeling Requirements for Pesticides and Devices, Container Labeling and Pesticide Management and Disposal regulations found in Title 40 of the Code of Federal Regulations (CFR) ~~2008~~ 2009 Revision, Part 156.140 et seq. and Part 165 et seq. for the United States Environmental Protection Agency (EPA) as promulgated and amended in the Federal Register, are hereby adopted in their entirety.

(b) All words or terms defined or used in the federal regulations incorporated by reference shall mean the state equivalent or counterpart to those words or terms.

[OAR Docket #10-543; filed 4-7-10]

**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 30. CONSUMER PROTECTION**

[OAR Docket #10-542]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 17. Combined Pesticide
Part 11. Standards for Application of Pesticide
35:30-17-27 [REVOKED]

AUTHORITY:
State Board of Agriculture; 2 O.S. §§ 2-4 (2) and (29) and 3-84(b); Article 6, Section 31, Constitution of the State of Oklahoma

DATES:
Comment period:
October 1, 2009 through November 2, 2009

Public hearing:
November 2, 2009

Adoption:
November 18, 2009

Submitted to Governor:
November 18, 2009

Submitted to House:
November 18, 2009

Submitted to Senate:
November 18, 2009

Gubernatorial approval:
December 18, 2009

Legislative approval:
Failure of the Legislature to disapprove the rules resulted in approval on March 24, 2010

Final adoption:
March 24, 2010

Effective:
July 1, 2010

SUPERSEDED EMERGENCY ACTIONS:
N/A

INCORPORATIONS BY REFERENCE:
N/A

ANALYSIS:
The proposed rule revokes the provisions in the combined pesticide rules related to fluoroacetate compounds. Pursuant to a federal court, fluoroacetate compounds are no longer available for rodent control, therefore the rule unnecessary. US EPA requested the Department to revoke the rule to ensure the pesticide program continues to follow federal law.

CONTACT PERSON:
Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry
(405) 522-4576

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 JULY 1, 2010:

SUBCHAPTER 17. COMBINED PESTICIDE

PART 11. STANDARDS FOR APPLICATION OF PESTICIDE

35:30-17-27. Fluoroacetate compounds [REVOKED]
(a) ~~The term "Fluoroacetate compounds", shall mean Sodium Fluoroacetate (Compound 1080), Fluoroacetamide (Compound 1081), or related Fluoroacetate mixtures, formulation, dilutions, or combinations.~~
(b) ~~For rodent control the use of Fluoroacetate compounds, as defined in (a) of this Section, is prohibited without written authorization granted by the Department. The authorization may only be granted following a written request including justification of the need for the use, documentation that all alternative rodent control methods have been tried and found to be ineffective, demonstration that the public health and welfare is in jeopardy, and any other requirements specified by the Board to safeguard the public health, safety, and welfare.~~

Permanent Final Adoptions

(e) For predatory animal control, the use of Fluoroacetate compounds, as defined in (a) of this Section, is limited to applicators certified under the Bird and Predatory Animal Control category and approved by U. S. Fish and Wildlife.

[OAR Docket #10-542; filed 4-7-10]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 37. FOOD SAFETY

[OAR Docket #10-544]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Meat Inspection

Part 1. General Provisions

35:37-3-1 [AMENDED]

35:37-3-3 [AMENDED]

Subchapter 5. Poultry Products Inspection

Part 1. General Provisions

35:37-5-1 [AMENDED]

35:37-5-2 [AMENDED]

AUTHORITY:

Oklahoma State Board of Agriculture; 2 O.S. §§ 2-4, 6-181 et seq.; 6-251 et seq.; 6-280-1 et seq., and 6-290.1 et seq.; Article 6, Section 31, Constitution of the State of Oklahoma

DATES:

Comment period:

September 1, 2009 through October 1, 2009

Public hearing:

October 1, 2009

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SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

Incorporated standards:

Mandatory Meat Inspection Regulations, Title 9, Code of Federal Regulations (CFR) (2009 Revision)-Various Parts, with exceptions.

Incorporating rules:

35:37-3-1 and 35:37-3-3

35:37-5-1 and 35:37-5-2

Availability:

8:00 a.m. to 5:00 p.m., Monday through Friday at the Oklahoma Department of Agriculture, Food, and Forestry, 2800 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4298, 405-522-4576

ANALYSIS:

The proposed rule changes update the incorporation by reference of Code of Federal Regulations citations.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry, (405) 522-4576

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 JULY 1, 2010:

SUBCHAPTER 3. MEAT INSPECTION

PART 1. GENERAL PROVISIONS

35:37-3-1. Incorporation by reference of federal meat inspection regulations

The Mandatory Meat Inspection Regulations found in Title 9 of the Code of Federal Regulations (CFR) (~~2008~~ 2009 Revision), Parts 301 to 391; 416; 417; 424; 430; 441; and 500 for the United States Department of Agriculture (USDA) as promulgated and amended in the Federal Register, are hereby adopted in their entirety with the exception of the deleted regulations specified in 35:37-3-3. Whenever an official mark, form, certificate or seal is designated by federal regulations, the appropriate Oklahoma Department of Agriculture, Food, and Forestry form, certificate or seal shall be substituted.

35:37-3-3. Deleted regulations

The following sections of the Federal regulations governing the mandatory meat inspection of the USDA incorporated by reference under 35:37-3-1 are deleted and are not rules of the Oklahoma Department of Agriculture, Food, and Forestry: 9 CFR 302.2; 303.1(c); 304.1; 304.2(a); 304.2(c); 305.2(b); 307.4; 307.5; 307.6; 316.12; 316.13(c); 317.5; 317.7; 317.9; 317.13; 318.8; 318.12; 321; 322; 327; 329.6; 329.7; 329.8; 329.9; 331; 335; 351; 352; 354; 355; 362; 381; 390; 391; and 590 (~~2008~~ 2009 Revision).

SUBCHAPTER 5. POULTRY PRODUCTS INSPECTION

PART 1. GENERAL PROVISIONS

35:37-5-1. Definitions and incorporation by reference of federal poultry inspection regulations

(a) The Mandatory Poultry Inspection Regulations found in Title 9 of the Code of Federal Regulations (CFR) (~~2008~~ 2009 Revision), Parts 381; 416; 417; 424; 430; 441; and 500 for the United States Department of Agriculture (USDA) as promulgated and amended in the Federal Register, are hereby adopted in their entirety with the exception of the deleted regulations specified in 35:37-5-2. Whenever an official mark, form, certificate or seal is designated by federal regulations, the appropriate Oklahoma Department of Agriculture, Food, and Forestry mark, form, certificate or seal shall be substituted.

(b) All words and terms defined or used in the federal regulations incorporated by reference by the Department shall mean the state equivalent or counterpart to those words or terms.

(c) The following terms, when used in this subchapter, shall have the following meaning unless the context clearly indicates otherwise:

- (1) **"Act"** means the Oklahoma Poultry Products Inspection Act.
- (2) **"Director"** means the Director of Meat Inspection.
- (3) **"Poultry"** means any domesticated bird, whether live or dead, including chickens, turkeys, ducks, geese, guineas, ratites, or squabs (also known as young pigeons from one to about thirty (30) days of age).
- (4) **"Poultry product"** means any poultry carcass, part, or product made wholly or in part from any poultry carcass or part that can be used as human food, except those exempted from definition as a poultry product in Title 9 of the Code of Federal Regulations (CFR), Part 381.15. This term shall not include detached ova.
- (5) **"Poultry byproduct"** means the skin, fat, gizzard, heart, or liver, or any combination of any poultry for cooked, smoked sausage.

35:37-5-2. Deleted regulations and exemptions

(a) The following sections of the Federal regulations governing the mandatory poultry inspection (9 CFR, Part 381 et seq.; 416 et seq.; 417 et seq.; 424 et seq.; 441 et seq.; and 500 et seq.), (~~2008~~ 2009 Revision) of the USDA incorporated by reference under 35:15-27-1 are deleted and are not rules of the Oklahoma Department of Agriculture, Food, and Forestry: 381.6; 381.10(a)(2), (5), (6), and (7); 381.10(b); 381.10(d)(2)(i); 381.13(b); 381.16; 381.17; 381.20; 381.21; 381.37; 381.38; 381.39; 381.96; 381.101; 381.103 through 381.112; 381.123(b)(1) and (4); 381.132(c); 381.133; 381.179; 381.185; 381.186; and 381.195 through 381.225.

(b) The provisions of this Act and rules do not apply to poultry producers who slaughter their own poultry raised on their farm, and each of the following apply:

- (1) The producers slaughter no more than two hundred and fifty (250) turkeys or their equivalent with a ratio of four (4) birds of other species, excluding ratites, to one (1) turkey during a calendar year;
- (2) The producers do not engage in buying or selling poultry products other than those produced from poultry raised on their own farms;
- (3) The poultry and poultry products do not move in commerce. Poultry producers are prohibited from selling or donating uninspected poultry products to retail stores, brokers, meat markets, schools, orphanages, restaurants, nursing homes, and other similar establishments and are prohibited from sales or donation of uninspected poultry through any type of retail market or similar establishment owned or operated by the poultry producer;
- (4) The producers submit a certificate of registration to the Board;
- (5) The poultry is healthy, the poultry is slaughtered and processed under sanitary standards, practices, and

procedures that result in the preparation of poultry products that are sound, clean, and fit for human food, and each carcass, part, or poultry product bears a label that lists the customer's name, the producer's name, and the following statement, "This poultry product has not been inspected and passed";

- (6) The poultry is sold directly to the household consumer and transported by either the household consumer or the poultry producer without third-party intervention or intervening transfer or storage, and is maintained in a safe and unadulterated condition during transportation; and
- (7) The poultry producers, allow an authorized agent of the Board access to their facilities and an opportunity to examine records at all reasonable times upon notice.

[OAR Docket #10-544; filed 4-7-10]

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

[OAR Docket #10-545]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Concentrated Animal Feeding Operations
35:44-3-3 [AMENDED]

AUTHORITY:

Oklahoma State Board of Agriculture; 2 O.S. §§ 2-4(2), 2-18.2, 2A-1 et seq., and 2A-21 et seq.; 27A O.S. § 1-3-101(D); and Article 6, Section 31, Constitution of the State of Oklahoma

DATES:

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July 1, 2010

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

Incorporated standards:

Updates references to 40 CFR, as published on July 1, ~~2008~~2009

Incorporating rules:

35:44-3-3

Availability:

8:00 a.m. to 5:00 p.m., Monday through Friday at Oklahoma Department of Agriculture, Food, and Forestry, 2800 North Lincoln Boulevard, Oklahoma City, OK 73105-4298, 405-522-4576

Permanent Final Adoptions

ANALYSIS:

This rule updates the Code of Regulation Regulations date for the incorporation by reference of the permitting requirements for concentrated animal feeding operations.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry
(405) 522-4576

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 JULY 1, 2010:

SUBCHAPTER 3. CONCENTRATED ANIMAL FEEDING OPERATIONS

35:44-3-3. Date of federal regulations incorporated

When reference is made to 40 CFR it means, unless otherwise specified, the volume of 40 CFR as published on July 1, ~~2008~~2009.

[OAR Docket #10-545; filed 4-7-10]

TITLE 120. CAPITOL-MEDICAL CENTER IMPROVEMENT AND ZONING COMMISSION CHAPTER 10. ZONING REGULATIONS FOR CAPITOL-MEDICAL CENTER IMPROVEMENT AND ZONING DISTRICT

[OAR Docket #10-475]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions

120:10-1-3 [AMENDED]

Subchapter 3. Specific District Regulations

120:10-3-1 [REVOKED]

120:10-3-1.1 [NEW]

120:10-3-2 [REVOKED]

120:10-3-2.1 [NEW]

120:10-3-3 [REVOKED]

120:10-3-3.1 [NEW]

120:10-3-4 [REVOKED]

120:10-3-4.1 [NEW]

120:10-3-5 [REVOKED]

120:10-3-5.1 [NEW]

120:10-3-6 [REVOKED]

120:10-3-6.1 [NEW]

120:10-3-7 [REVOKED]

120:10-3-7.1 [NEW]

120:10-3-8 [AMENDED]

120:10-3-8.1 [RESERVED]

120:10-3-9 [REVOKED]

120:10-3-9.1 [NEW]

120:10-3-10 [REVOKED]

120:10-3-10.1 [NEW]

120:10-3-11 [REVOKED]

120:10-3-11.1 [NEW]

Subchapter 5. General District Provision and Additional Zoning Regulations

120:10-5-1.1 [REVOKED]

120:10-5-1.2 [NEW]

120:10-5-2 [REVOKED]

120:10-5-2.1 [NEW]

120:10-5-3 [REVOKED]

120:10-5-3.1 [NEW]

120:10-5-4 [REVOKED]

120:10-5-4.1 [NEW]

120:10-5-5 [REVOKED]

120:10-5-5.1 [NEW]

120:10-5-6 [REVOKED]

120:10-5-6.1 [NEW]

120:10-5-9 [REVOKED]

120:10-5-9.1 [NEW]

120:10-5-10 [REVOKED]

120:10-5-10.1 [NEW]

120:10-5-11 [REVOKED]

120:10-5-11.1 [NEW]

120:10-5-12 [REVOKED]

120:10-5-12.1 [NEW]

120:10-5-14 [AMENDED]

Subchapter 9. Non-conforming Buildings, Structures and Uses of Land

120:10-9-1 [REVOKED]

120:10-9-1.1 [NEW]

Subchapter 11. Historical Preservation and Landmark Board of Review

120:10-11-1 [REVOKED]

120:10-11-1.1 [NEW]

120:10-11-2 [REVOKED]

120:10-11-2.1 [NEW]

120:10-11-3 [REVOKED]

120:10-11-3.1 [NEW]

120:10-11-4.1 [RESERVED]

120:10-11-5 [REVOKED]

120:10-11-5.1 [NEW]

120:10-11-6 [REVOKED]

120:10-11-6.1 [NEW]

120:10-11-7 [REVOKED]

120:10-11-7.1 [NEW]

120:10-11-8 [REVOKED]

120:10-11-8.1 [NEW]

120:10-11-9 [REVOKED]

120:10-11-9.1 [NEW]

120:10-11-10 [REVOKED]

120:10-11-10.1 [NEW]

120:10-11-11 [REVOKED]

120:10-11-11.1 [NEW]

Subchapter 13. Administration

120:10-13-1 [REVOKED]

120:10-13-1.1 [NEW]

120:10-13-2 [REVOKED]

120:10-13-2.1 [NEW]

120:10-13-3 [REVOKED]

120:10-13-3.1 [NEW]

120:10-13-4 [REVOKED]

120:10-13-4.1 [NEW]

120:10-13-5 [REVOKED]

120:10-13-5.1 [NEW]

120:10-13-6 [REVOKED]

120:10-13-6.1 [NEW]

120:10-13-7 [REVOKED]

120:10-13-7.1 [NEW]

120:10-13-8 [REVOKED]

120:10-13-8.1 [NEW]

120:10-13-9 [REVOKED]

120:10-13-9.1 [NEW]

120:10-13-10 [REVOKED]

120:10-13-10.1 [NEW]

120:10-13-11 [REVOKED]

120:10-13-11.1 [NEW]

120:10-13-12 [REVOKED]

120:10-13-12.1 [NEW]

Appendix A. Capitol-Medical Center Improvement and Zoning District Maps [REVOKED]

Appendix A.1. Capitol-Medical Center Improvement and Zoning District Maps [NEW]

Appendix B. Official Height Zoning Map [REVOKED]
 Appendix B.1. Official Height Zoning Map [NEW]
 Appendix C. State Capitol Complex Subdistrict [REVOKED]
 Appendix C.1. State Capitol complex Subdistrict [NEW]
 Appendix F. Comprehensive Master Plan - 1978 [NEW]
 Appendix G. Comprehensive Plan Update - 1994 [NEW]

AUTHORITY:

Capitol-Medical Center Improvement and Zoning Commission, 73 O.S.,
 Section 83.4

DATES:

Comment Period:

November 2, 2009 through December 17, 2009

Public Hearing:

December 18, 2009

Adoption:

December 18, 2009

Submitted to Governor:

December 28, 2009

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December 28, 2009

Submitted to Senate:

December 28, 2009

Gubernatorial approval:

January 20, 2010

Legislative approval:

Failure of the Legislature to disapprove the rules resulted in approval on
 March 24, 2010

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June 22, 2009

Register publication:

26 Ok Reg 2820

Docket number:

09-1202

SUPERSEDED EMERGENCY ACTIONS:

Subchapter 3. Specific District Regulations

120:10-3-1.1 [NEW]

120:10-3-2.1 [NEW]

120:10-3-3.1 [NEW]

120:10-3-4.1 [NEW]

120:10-3-5.1 [NEW]

120:10-3-6.1 [NEW]

120:10-3-7.1 [NEW]

120:10-3-8.1 [RESERVED]

120:10-3-9.1 [NEW]

120:10-3-10.1 [NEW]

120:10-3-11.1 [NEW]

Subchapter 5. General District Provision and Additional Zoning
 Regulations

120:10-5-1.2 [NEW]

120:10-5-2.1 [NEW]

120:10-5-3.1 [NEW]

120:10-5-4.1 [NEW]

120:10-5-5.1 [NEW]

120:10-5-6.1 [NEW]

120:10-5-9.1 [NEW]

120:10-5-10.1 [NEW]

120:10-5-11.1 [NEW]

120:10-5-12.1 [NEW]

Subchapter 9. Non-Conforming Buildings, Structures and Uses of Land

120:10-9-1.1 [NEW]

Subchapter 11. Historical Preservation and Landmark Board of Review

120:10-11-1.1 [NEW]

120:10-11-2.1 [NEW]

120:10-11-3.1 [NEW]

120:10-11-4.1 [RESERVED]

120:10-11-5.1 [NEW]

120:10-11-6.1 [NEW]

120:10-11-7.1 [NEW]

120:10-11-8.1 [NEW]

120:10-11-9.1 [NEW]

120:10-11-10.1 [NEW]

120:10-11-11.1 [NEW]

Subchapter 13. Administration

120:10-13-1.1 [NEW]

120:10-13-2.1 [NEW]

120:10-13-3.1 [NEW]

120:10-13-4.1 [NEW]

120:10-13-5.1 [NEW]

120:10-13-6.1 [NEW]

120:10-13-7.1 [NEW]

120:10-13-8.1 [NEW]

120:10-13-9.1 [NEW]

120:10-13-10.1 [NEW]

120:10-13-11.1 [NEW]

120:10-13-12.1 [NEW]

Appendix A.1. Capitol-Medical Center Improvement and Zoning District
 Maps [NEW]

Appendix B.1. Official Height Zoning Map [NEW]

Appendix F. Comprehensive Master Plan - 1978 [NEW]

Appendix G. Comprehensive Plan Update - 1994 [NEW]

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

These rules replace 2009 emergency rules adopted after a court decision essentially invalidated the majority of the Commission's existing rules, which were promulgated under 73 O.S. secs. 82.1 - 83.14, rather than the APA. The rules establish regulations and provide information related to zoning requirements in compliance with Title 73, Section 82.1 O.S. and in support of the recommended policies and goals of the Capitol-Medical Center Improvement and Zoning District Master Plan. Rules.

Subchapter 11 creates the State Capitol Historical Preservation and Landmark board of Review within the Commission, providing membership, duties and powers of the Board. Criteria for the Historic preservation District or Historical Landmark District is included in this Subchapter, including procedures for requesting and approval of permits by the Commission for such district.

Subchapter 13 provides information and procedures related to District building permits, conditional uses, and certificates of occupancy reviewed and approved by the Commission. Appeal procedures related to decisions by the Commission are included in this subchapter.

CONTACT PERSON:

Gerry Smedley, Administrative Rules Liaison, (405) 522-8519, Department of Central Services, 2401 N. Lincoln Blvd., Suite 206, Oklahoma City, OK 73105; or, Denise Martin, Administrative Officer, Capitol-Medical Center Improvement and Zoning Commission, (405) 521-3678, 2401 N. Lincoln Blvd., Suite 112, Oklahoma City, OK 73105.

DUE TO EXCESSIVE LENGTH OF THESE RULES (AS DEFINED IN OAC 655:10-7-12), THE FULL TEXT OF THESE RULES WILL NOT BE PUBLISHED. THE RULES ARE AVAILABLE FOR PUBLIC INSPECTION AT THE DEPARTMENT OF CENTRAL SERVICES, 2401 N. LINCOLN BOULEVARD, WILL ROGERS OFFICE BUILDING, SUITE 206, OKLAHOMA CITY, OKLAHOMA, AND AT THE SECRETARY OF STATE'S OFFICE OF ADMINISTRATIVE RULES. THE FOLLOWING SUMMARY HAS BEEN PREPARED PURSUANT TO 75 O.S., SECTION 255(B):

SUMMARY:

Content of the adopted rules include the emergency rules adopted in 2009, which are all rules the Commission administered prior to June, 2009 that were adopted pursuant to Attorney General Opinion 74-149 related to the Commission's rulemaking authority granted under 73 O.S. Sections 82.1 - 83.14 rather than the Administrative Procedures Act (APA). The Commission was compelled to adopt the rules pursuant to the APA when a court decision overturned the AG opinion. The Commission took the opportunity to amend the rules to clean up grammatical and scrivener errors, as well as replace some map graphics in appendices during this rulemaking action.

Commission rules prescribe zoning regulations, which include height restrictions, number of stories and size of buildings, the percentage of lots that may be occupied, the size of yards, courts, and other open spaces, the density of population, the location and use of buildings, structures and land, for trade, industry, residence, recreation, or other purposes; the identification of subdistricts within the statutory District and regulations for each, as provided by law, in order to promote the general welfare of the state in respect to the

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State Capitol, other state properties and the Medical Center of the University of Oklahoma, and the surrounding area; and to promote the general welfare of the several property owners of the area.

The rules include creation of the Historical Preservation and Landmark Board of Review, provide for its membership and duties; and the Commission's role with the Board of Review; information and procedures for designation of an Historic Preservation District and an Historical Landmark District; and issuance of a Certificate of Appropriateness by the Commission. Subchapter 13 is the section of rules providing rules and information about the administrative operations of the Commission, which includes building permits, certificates of occupancy, Commission public hearing procedures, procedures to amend zoning regulations or zoning map, appeals to the Commission, appeals to the District Court, powers relative to conditional uses permissible on review, enforcement etc.

[OAR Docket #10-475; filed 4-1-10]

TITLE 165. CORPORATION COMMISSION CHAPTER 65. WATER SERVICE UTILITIES

[OAR Docket #10-533]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 9. Records, Reports, and Filing Requirements
165:65-9-11. Relief from rate increase requirements [NEW]

AUTHORITY:

Oklahoma Corporation Commission
Article IX, Section 18, Oklahoma Constitution
17 Okla. Stat. § 152

DATES:

Comment Period:

September 16, 2009 through January 8, 2010

Public Hearing:

January 21, 2010

Adoption:

January 21, 2010

Submitted to the Governor:

January 27, 2010

Submitted to the House:

January 27, 2010

Submitted to Senate:

January 27, 2010

Gubernatorial approval:

February 9, 2010

Legislative approval:

Failure of the Legislature to disapprove the rules resulted in approval on March 24, 2010.

Final Adoption:

May 24, 2010

Effective Date:

July 1, 2010

SUPERSEDED EMERGENCY ACTIONS:

None

INCORPORATIONS BY REFERENCE:

None

ANALYSIS:

OAC 165:65-9-11 has been promulgated to establish a process whereby smaller water utilities, having less than \$250,000 in annual gross revenues in Oklahoma, would be permitted to increase customers' rates and charges by an amount which is no greater than ten percent (10%) of the water utilities' previous 12 months gross revenues generated by the existing water usage rates, without filing a general rate review under the regulations set forth in Oklahoma Administrative Code (OAC) 165:70-7-4. The water utilities would be permitted to increase their charges and rates in such manner for no more than two consecutive years and no more than three years within the most recent five year period.

The water utilities would be required to provide advance notice to their customers through no less than two separate billing cycles with the second

notice being given at least sixty (60) days in advance of the effective date of the proposed increases. Customer notices would provide the effective date of the proposed rate and charge increases, the average increase per customer per rate class, the total percentage of increase, and the procedure for customers to petition the Commission to examine the proposed increases should fifteen percent (15%) or more of the customers find the proposed increases objectionable.

The water utilities would also be required to notify the Oklahoma Corporation Commission (Commission) at least seventy-five (75) days in advance of the proposed increases. Notice to the Commission must include: a copy of the notice provided to customers, a verified statement showing the total number, and types, of customers as of the date of the water utility's most recent billing, a verified statement showing the water utility's total gross revenue for the previous twelve (12) months, a copy of the water utility's approved tariff sheet showing existing and proposed rates, and, the date of the water utility's most recent annual report in accordance with OAC 165:65-9-10(d)-(g). Rate and charge increases effectuated through this procedure would be in force for at least one year and during said year no additional increases would be permitted unless mandated by change in state or federal law, or through a general rate case filing.

CONTACT PERSON:

Don A. Schooler, Assistant General Counsel, Office of General Counsel, Oklahoma Corporation Commission. 2101 N Lincoln Blvd, PO Box 52000, Oklahoma City, OK 73152-2000, 405/522-0482.

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 JULY 1, 2010:

SUBCHAPTER 9. RECORDS, REPORTS, AND FILING REQUIREMENTS

165:65-9-11. Relief from rate increase requirements

(a) Class C or D water utilities, having less than \$250,000 in annual gross revenue within the state, shall not be subject to the requirements of OAC 165:70-7-4 rate regulation as prescribed in Chapter 70, the general rate regulation requirements, unless a water utility proposes an increase in rates and charges which exceeds a ten percent (10%) annual increase in revenue, based on the previous twelve (12) months gross revenue generated by the existing water usage rates.

(b) A water utility may not submit more than two (2) consecutive annual submissions using the provisions of this Subchapter, nor may a water utility submit more than three (3) submissions within the most recent five (5) year period using the procedures set forth in this Subchapter.

(c) Each water utility desiring to increase its water rates pursuant to this section shall provide notice to its water customers in no less than two (2) billing cycles with the second notice being given at least sixty (60) days before the effective date of the proposed rate increase. Notice shall be made by regular mail or personal service and be included with each customer's regular bill. Notice to the water utility's customers shall include the following:

- (1) Existing rate and proposed rate;
- (2) Average dollar increase per customer per rate class;
- (3) Percentage of total company regulated revenues increase; and

- (4) The procedure necessary for a customer to petition the Commission to examine and determine the reasonableness of the proposed rate increase, pursuant to Section (h) of this Subchapter.
- (d) Each water utility desiring to increase its water rates pursuant to this section shall notify the Commission at least seventy-five (75) days before the effective date of the proposed rate increase. Notice to the Commission shall include the following:
- (1) A copy of the notice to be provided to its customers;
 - (2) Verified statement showing the total number of customers of the water utility as of the date of the most recent billing;
 - (3) Verified statement showing the water utility's total gross revenue for the previous twelve (12) months;
 - (4) The date of the water utility's last rate increase, the cause number and the final order number, if available;
 - (5) Any anticipated growth or decline in the water utility's customers which is expected to occur during the first twelve (12) months following the proposed rate increase;
 - (6) The types of customers the water utility serves;
 - (7) A copy of the water utility's approved tariff sheet showing the existing rates and proposed new rates;
 - (8) The date of the most recent annual report in accordance to 165:65-9-10(d)-(g).
- (e) If, thirty (30) days prior to the effective date of this proposed increase in rates and charges, the Commission has received petitions from fewer than 15% of the affected customers, requesting that the Commission examine the proposed increase in rates and charges, the Commission shall notify the water utility that the rate increase may be implemented on the proposed effective date and shall apply to all bills normally rendered on and after the effective date.
- (f) If, thirty (30) days prior to the effective date of the proposed increase in rates and charges, the Commission has received petitions from 15% or more of the affected customers, then the Commission shall notify the water utility that it will examine and determine the reasonableness of the proposed increase in rates and charges and the rate increase may not be initiated until the Commission has completed its determination.
- (g) A water utility shall not increase its rates and charges under this Section more than once in any twelve (12) month period. If a water utility is eligible to increase its rates and/or charges pursuant to this Section and desires to increase its rates and/or charges above that which is allowed under this Section, it shall file an application pursuant to the Commission's applicable rules, unless otherwise allowed by law.
- (h) A petition submitted to the Director of the Public Utility Division requesting the Commission to examine and determine the reasonableness of a water utility's proposed increase in rates and charges shall be in substantially the following form:
- (1) Form: The petition shall be headed by a caption, which shall contain:
 - (A) The name of the utility seeking an increase in rates and charges; and
 - (B) The relief sought.
 - (2) Body: The body of the petition shall contain the following:

- (A) All allegations of facts, without unnecessary detail, explaining why the customers oppose the increase in rates;
 - (B) A reference that the petition is submitted pursuant to OAC 165:65-9-11;
 - (C) The name, address, telephone number, and signature of each petitioning customer; and
 - (D) A copy of the notice provided by the water utility and received by one of the customers signing the petition shall be attached to the petition.
- (i) Petitions may be signed only by the affected customers of the water utility. Only one signature per meter shall be counted to determine if the fifteen percent (15%) threshold has been met.

[OAR Docket #10-533; filed 4-7-10]

**TITLE 300. GRAND RIVER DAM
AUTHORITY
CHAPTER 10. PUBLIC PURPOSE SUPPORT
AND ASSISTANCE**

[OAR Docket #10-466]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
300:10-1-2. [AMENDED]

AUTHORITY:
Grand River Dam Authority; 82 O.S. § 861 *et seq.*; 82 O.S.Supp.2009, § 862; 82 O.S. § 875

DATES:
Comment period:
January 16, 2009 through February 16, 2009

Public hearing:
March 11, 2009

Adoption:
April 8, 2009

Submitted to Governor:
April 9, 2009

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April 9, 2009

Submitted to Senate:
April 9, 2009

Gubernatorial approval:
May 14, 2009

Legislative approval:
March 24, 2010

Final adoption:
March 24, 2010

Effective:
May 13, 2010

SUPERSEDED EMERGENCY ACTIONS:
N/A

INCORPORATIONS BY REFERENCE:
N/A

ANALYSIS:
These rules prescribe the circumstances under which the Grand River Dam Authority would approve or deny requests for financial assistance to qualified groups to promote economic/industrial development, tourism and recreational activities and conservation and development of natural resources in the communities and industrial areas the Authority serves, all of which are deemed to be governmental public purposes. Such support and assistance would include marketing, consumer education, community relations and customer service functions which the Authority performs.

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CONTACT PERSON:

Gretchen Zumwalt-Smith, General Counsel, Grand River Dam Authority,
P.O. Box 409, Vinita, OK 74301, (918) 256-5545

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 MAY 13, 2010:

300:10-1-2. Policy

(a) GRDA supports and assists activities, organizations, and causes which advance both governmental public purposes, as well as corporate purposes of GRDA by promoting community and economic development, tourism and recreational activities, and conservation and development of natural resources in the communities and industrial areas it serves. This support and assistance will be in compliance with state laws governing GRDA's activities including marketing, consumer education, community relations and customer service functions which it performs.

(b) GUIDELINES FOR GRDA'S SUPPORT

(1) GRDA may support the following state, regional and local organizational types:

- (A) ~~Community and Economic Development Organizations~~
- (B) Chambers of Commerce
- (C) ~~Tourism and Recreational Organizations~~
- (D) Agricultural Organizations
- (E) Environmental Organizations
- ~~(F) Other similar public and private agencies~~
- (F) Political Subdivisions
- (G) Industrial Committees
- (H) Other similar public and private agencies

(2) GRDA may support and assist communities and/or projects located within the boundaries of the district that are served by GRDA, in which any of its assets are located.

(3) A budget per community/area will be set based on what is in the best interest of GRDA. Factors taken into consideration will include the number of citizens benefiting from the programs/projects, revenue to GRDA, and the overall need of the community and/or project. Any support and assistance provided by GRDA shall be at its sole discretion, provided however, that such support and assistance shall be limited to an amount not to exceed a total of ~~fifteen thousand dollars (\$15,000)~~ twenty-five thousand dollars (\$25,000) per year for one (1) or more projects or efforts that are for the benefit of or impact the quality of life for each city or community ~~which GRDA serves or in which it has assets~~ located within the boundaries of the district.

(4) GRDA will not monetarily support the following:

- (A) Individuals
- (B) Political campaigns/parties
- (C) Religious organizations
- (D) Private Schools
- (E) Private for-profit organizations
- (F) Solicitations received by form letters

(G) Groups that discriminate on the basis of age, race, sex, or national origin

(H) Activities, organizations or causes which do not advance a public purpose and a GRDA corporate purpose

(c) RESPONSIBILITIES AND EVALUATION OF REQUESTS

(1) Community Relations Department will:

(A) Budget for support and assistance.

(B) Classify all expenditure requests for accounting purposes.

(C) Evaluate requests to determine whether they meet a public purpose and a corporate purpose ~~within guidelines established by GRDA management and the Board of Directors.~~

(D) Process requests including ensuring required approvals.

(E) Prepare a quarterly report summarizing expenditures disbursements for presentation to the Board.

(F) Perform evaluations on expenditure disbursements.

(i) All ~~\$10,000 or greater~~ expenses will be evaluated and documented on a quarterly basis.

(2) Requester will submit request for monetary support to the Community Relations Director. It should contain a concise proposal which may include:

(A) Purpose and mission of group requesting funds.

(B) Expected or intended results for use of funds.

(C) Such other documentation as is appropriate to evaluate the request.

(d) APPROVAL PROCESS

(1) The only GRDA employee authorized to process requests for support and assistance will be the Community Relations Director.

(2) The following approval levels are applicable to the total commitment made to any single request:

(A) Expenditures \$2,500 or below shall be approved by the Community Relations Director

(B) Expenditures greater than \$2,500 shall be approved by the Chief Executive Officer and/or the Chief Operating Officer

[OAR Docket #10-466; filed 3-31-10]

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

[OAR Docket #10-574]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. Organization and Administration

317:1-1-8. [AMENDED]

317:1-1-9. [AMENDED]

317:1-1-9.1. [NEW]

317:1-1-10. [REVOKED]

317:1-1-17. [AMENDED]
 Subchapter 3. Formal and Informal Procedures
 317:1-3-3.1. [AMENDED]
 317:1-3-3.2. [REVOKED]
 317:1-3-4. [NEW]
 Subchapter 5. Compliance with Section 504 of the Rehabilitation Act of 1973 [REVOKED]
 317:1-5-1. through 317:1-5-5. [REVOKED]
 Subchapter 7. Compliance with the Americans with Disabilities Act of 1990 [REVOKED]
 317:1-7-1. through 317:1-7-8. [REVOKED]
 Subchapter 9. Civil Rights and Nondiscrimination [REVOKED]
 317:1-9-1. through 317:1-9-6. [REVOKED]
 317:1-9-9. through 317:1-9-10. [REVOKED]
(Reference APA WF # 09-37)

AUTHORITY:

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

DATES:

Comment period:

December 16, 2009 through January 14, 2010

Public hearing:

January 19, 2010

Adoption:

February 11, 2010

Submitted to Governor:

February 11, 2010

Submitted to House:

February 11, 2010

Submitted to Senate:

February 11, 2010

Gubernatorial approval:

March 3, 2010

Legislative approval:

Failure of the Legislature to disapprove the rule(s) resulted in approval on April 8, 2010

Final adoption:

April 8, 2010

Effective:

May 13, 2010

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 1. Organization and Administration
 317:1-1-8. [AMENDED]
 317:1-1-9. [AMENDED]
 317:1-1-9.1. [NEW]
 317:1-1-10. [REVOKED]
 317:1-1-17. [AMENDED]
 Subchapter 3. Formal and Informal Procedures
 317:1-3-3.1. [AMENDED]
 317:1-3-3.2. [REVOKED]
 317:1-3-4. [NEW]
 Subchapter 5. Compliance with Section 504 of the Rehabilitation Act of 1973 [REVOKED]
 317:1-5-1. through 317:1-5-5. [REVOKED]
 Subchapter 7. Compliance with the Americans with Disabilities Act of 1990 [REVOKED]
 317:1-7-1. through 317:1-7-8. [REVOKED]
 Subchapter 9. Civil Rights and Nondiscrimination [REVOKED]
 317:1-9-1. through 317:1-9-6. [REVOKED]
 317:1-9-9. through 317:1-9-10. [REVOKED]

Gubernatorial approval:

November 3, 2009

Register publication:

27 Ok Reg 284

Docket number:

09-1368

(Reference APA WF # 09-37)

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rule revisions are needed to remove unnecessary policy concerning certain federal requirements, to correct references to federal laws and state statute,

amend policy on open records requirements and include a process for ensuring proper review and approval/disapproval by the Oklahoma Health Care Authority for rate methodology changes. References to federal regulations regarding employment of individuals with disabilities was removed as the Oklahoma Health Care Authority is exempt from compliance with certain parts of the regulation. Leaving references in policy will result in confusion over employer/employee rights and responsibilities, opening up the potential for unnecessary litigation against the agency. Additionally, the revised process for reviewing and approving/disapproving rate methodology changes must be reflected in policy in order to assist healthcare providers and the general public with knowledge about the public process for rate changes. Absent knowledge of the process, some individuals may miss the opportunity to provide valuable input regarding rate adjustments, potentially resulting in a lower quality of care for SoonerCare members.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 MAY 13, 2010:

SUBCHAPTER 1. ORGANIZATION AND ADMINISTRATION

317:1-1-8. Administrator

The Administrator is the chief executive officer of the Oklahoma Health Care Authority and acts for the Authority in all matters provided by law [63:5008]. The Administrator determines the internal organization of the Health Care Authority and employs staff as may be necessary to perform the duties of the Authority as authorized by statute. The Administrator is responsible for the development of all internal policies and procedures necessary for the Authority to carry out its functions and to achieve all short- and long-term agency goals. The powers and duties of the Administrator include supervision of all activities of the Authority, formulation and recommendation of rules for approval or rejection by the Authority Board and enforcement of rules promulgated by the Board. The Administrator is also responsible for directing the preparation of all plans, reports and proposals necessary for the agency's function or as required by law.

317:1-1-9. Location for information and for filing

- (a) Any person may obtain information from, make submission to, or make a request of the Authority by writing to: Oklahoma Health Care Authority, 4545 North Lincoln, Suite 124, Oklahoma City, Oklahoma 73105.
- (b) Written submissions and requests may be submitted in person between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday- or faxed to ~~The telephone number is (405) 530-3439-530-3214.~~
- (c) The date on which papers are actually received at the Authority will be recorded as the date of filing.

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317:1-1-9.1. Compliance with the Open Records Act

Oklahoma Statutes require compliance with the Open Records Act found at 51 O.S. §§ 24A.3-24A.29. The administrative regulations that follow are meant to clarify OHCA procedure and interpretation of state law regarding open records.

(1) Records request.

(A) A form is provided on OHCA's website that may be electronically mailed to the agency to request records from the Oklahoma Health Care Authority. The form may also be downloaded, completed and mailed to the agency. An open records form can be obtained by writing to the Open Records Coordinator, OHCA Legal Division, PO Drawer, 18497, Oklahoma City, Oklahoma 73154-0497.

(B) The person requesting records may also provide a written narrative at the address noted in paragraph (A). The written request must provide enough detail to allow the agency to ascertain the needs of the requestor. For example, a request asking for "all data relating to provider "b"" is not sufficient for the agency to properly answer the request. The reason the request in this example cannot be answered without further inquiry is that it has no time limitation nor any database information restriction. This type of request will be unavoidably delayed and eventually returned to the sender for additional information.

(C) In the event of any records request (electronic or otherwise) the agency will estimate the work involved in answering the request and bill the requestor either:

- (i) the reasonable direct cost of record copying or mechanical reproduction; or
- (ii) the reasonable cost of record search and the direct cost of record copying (or mechanical reproduction).

(D) The amount in paragraph (C)(i) is charged for all requests that are not solely for commercial purposes or requests that cause an excessive disruption of the essential functions of the public body.

(E) The amount in paragraph (C)(ii) is charged for all requests that are solely for commercial purposes or requests that cause an excessive disruption of the essential functions of the public body.

(F) OHCA generally waives the payment requirement from media searches and government agency searches because it considers these record requests to be matters of public interest.

(G) OHCA generally regards requests for pharmacy or other payment data as requests solely for commercial purposes.

(2) OHCA fees for copying and search.

(A) As required by law, OHCA posts its copying fees and search fees in the Oklahoma County Clerk's office and at its principal place of business.

(B) OHCA also posts its schedule on its public website at www.okhca.org. The legally recognized

schedule however, is the schedule posted at its principal place of business and County Clerk's office.

(C) OHCA's fee schedule specifically takes into account the statutory limit of fees for copying and certified copies.

(D) OHCA's fee schedule minimizes costs by using electronic data transmission when possible. Its fee schedule takes into account charges for electronic search and data devices (such as storage media).

(E) OHCA must receive any fees associated with the fee request before the records will be provided.

(3) **Open records request exceptions.** OHCA may deny requests in anticipation of litigation against the agency. The Oklahoma Civil Discovery Code is properly used for these requests. OHCA may deny open records requests for the reasons stated in any of the exceptions provided in the Open Records Act. The use of the exceptions is not to thwart the accountability of state government.

(4) **Timeliness of responses.** The agency endeavors to answer all record requests within a reasonable time as required by law. Generally a reasonable period of time is 30 days from receipt of a specific record request depending upon the following factors:

- (A) the ability to communicate with the requestor regarding federal or state law redaction requirements;
- (B) the workload within the agency regarding open record requests and program activity;
- (C) the inability to produce the record with or without redaction;
- (D) the specificity of the written request;
- (E) payment of the fee; and
- (F) the size and complexity of the data request.

317:1-1-10. Documents and records [REVOKED]

(a) Documents filed with or presented to the Authority will be retained in the files of the Authority for the length of time required by state and federal laws. Documents will be disposed of in a manner consistent with the Records Management Act, Sections 201 through 216 and 305 through 317 of Title 67 of the Oklahoma Statutes, and Sections 564 through 576 of Title 74 of the Oklahoma Statutes, which pertain to archives and records. The records disposition schedule for the Authority will be available for public inspection.

(b) Most records of the Authority are available for public inspection and release, but some are not. The records that are not available for general public access may include records described as confidential in this Section or in other Chapters in this Title, and other records that laws require or permit the Authority to keep confidential. The Authority normally keeps the following records confidential but may choose, in some cases, to make them public if law permits it:

- (1) Records which relate to internal personnel investigations including examination and selection material for employment, hiring, appointment, promotion, demotion, discipline, or resignation [51:24A.7(A)(2)(1)];
- (2) Before taking action, personal notes and personally created materials (other than the Authority's budget

request) prepared by the Authority staff as an aid to memory [51:24A.9];

(3) Before taking action, research material leading to the adoption of a policy or the implementation of a project [51:24A.9];

(4) Records coming into the possession of the Authority from the federal government or records generated or gathered as a result of federal legislation may be kept confidential to the extent required by federal law [51:24A.13]; and

(5) Documents, such as medical records and records protected by the attorney-client privilege, that are exempt from the Oklahoma Open Records Act or are specifically required or permitted by law to be kept confidential;

(e) In order to avoid giving unfair advantage to competitors or bidders, the Authority will keep confidential records relating to:

(1) Specifications for competitive bidding prior to publication by the public body;

(2) Prior to the opening of bids by the Authority or its representatives, the contents of sealed bids solicited through requests for proposals or requests for information under Department of Central Services purchasing rules or those established by the Oklahoma Health Care Authority, with the exception of procurements of managed care Health Plans; and

(3) State determined rates ranges established for the purpose of negotiating contract awards with qualified Health Plans for the Medicaid Managed Care program, including initial bid and subsequent bid offers prior to final contract awards.

(d) Except for the records described in this Section and records required by law to be kept confidential, all records of the Authority are available for public inspection in accordance with the Oklahoma Open Records Act, Sections 24A.1 through 24A.18 of Title 51 of the Oklahoma Statutes.

(e) Provisions for copying and search fees are contained in the statute, with these exceptions being noted; no copy fee is charged to other public entities, to applicants, recipients or their representatives, or employees or former employees seeking information from their case file or employment records; and no search fee is charged to news media, schools, authors, or "taxpayers seeking to determine whether those entrusted with the affairs of its government are honestly, faithfully, and competently performing their duties as public servants". The fees listed in (1) (4) of this Subsection may stand alone or be charged in combination. For example, a person may be charged a search fee in addition to a fee for photocopying.

(1) **Fees for photocopying.** The Authority has established a fee schedule for photocopying documents having the dimensions of 8 1/2 x 14 inches or smaller:

- (A) if less than 10 pages, 25 cents per page;
- (B) if between 10 and 100 pages, 10 cents per page; and
- (C) if over 100 pages, 5 cents per page, or a maximum of one dollar (\$1.00) per copied page for a certified copy.

(2) **Fees for search.** Requests that are for a commercial purpose or clearly would cause excessive disruption of office function will be charged a search fee of \$25.00 per hour for staff time spent in the search.

(3) **Fees for other types of reproduction.** Requests for computer runs, microfilming or reproduction other than photocopying, will be charged at the cost to the Authority of duplicating the information involved. Such requests are to be forwarded to the State Office where the fee will be developed with the appropriate division.

(4) **Payments of fees.** All fees are paid prior to delivering the copies, and if the request is for search only, the fee is paid before the person is allowed to review the material. All fees are paid by check or money order; cash is not accepted. The fee payment is transmitted to the State Office, Attention Division of Finance and Central Services. In addition, a receipt is to be given upon payment. A copy of the manual material is maintained to explain the fee schedules to interested persons.

317:1-1-17. Purchasing department

The Purchasing Department is the department within the Oklahoma Health Care Authority responsible for the acquisition of goods, equipment and services for the operation of the Oklahoma Health Care Authority and for acquisition of goods, equipment and services necessary for implementation of the Oklahoma Medicaid Health Care Options System SoonerCare Program. All acquisitions of the Purchasing Department are purchased under guidelines approved by the Oklahoma Health Care Authority and in compliance with all applicable state statutes.

SUBCHAPTER 3. FORMAL AND INFORMAL PROCEDURES

317:1-3-3.1. Drug Utilization Review Board

(a) The Oklahoma Medicaid SoonerCare Drug Utilization Review (DUR) Board shall be responsible for advising the Chief Executive Officer (hereinafter referred to as the CEO) of the Oklahoma Health Care Authority on retrospective and prospective drug utilization programs and review of formulary pharmacy benefit issues including clinical guideline applications.

(b) The DUR Board Members shall be appointed, and may be reappointed, by the CEO as provided by law.

317:1-3-3.2. DUR responsibility for Health Plan proposals for modifying medication coverage [REVOKED]

(a) Coverage of a medication by Health Plans is to be the same or exceed the coverage of the Oklahoma Health Care Authority (OHCA) fee for service program except as provided in (b) (1) (4) of this Section.

(b) The Health Plan must present in written text (See OAC 317:25-5-3) and the OHCA DUR Board will review as follows:

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- (1) ~~The non restricted covered medications per medication therapeutic category. Non restricted covered medications refer to covered medications which may be received by a member with a prescription and no additional review process.~~
- (2) ~~The review process per medication therapeutic category by which restricted medications are approved. Restricted medications refer to medications which may be received by member with a prescription and an additional review process, such as prior authorization or case management.~~
- (3) ~~The brand name exception process.~~
- (4) ~~The non covered medications. Non covered medications refer to medications which may not be obtained by a member in a Health Plan.~~
- (e) ~~Approval or non approval of a Health Plan medication coverage proposal will be based on the conditions listed in (1)-(5) of this subsection:~~
- (1) ~~Therapeutic appropriateness of proposed medication coverage;~~
- (2) ~~Functionality of proposed medication coverage;~~
- (3) ~~Probable impact on patient's therapeutic outcome, and the role of the physician and the application of the guidelines;~~
- (4) ~~Potential cost impact on non capitated or fee for services benefits;~~
- (5) ~~Inclusion of all therapeutic categories.~~
- (d) ~~The DUR Board may recommend the Health Plan's medication coverage proposal in its entirety, or limit the recommendation to specific components within the proposal. The Oklahoma Health Care Authority shall have final approval of all reviews by the DUR Board with regard to the medication coverage proposals submitted by Health Plans.~~

317:1-3-4. State Plan Amendment Rate Committee

(a) **Definitions.** Unless the context clearly indicates otherwise, the following words and terms when used in this section are defined as follows:

- (1) **Public Process** means a process as defined by federal law under 42 U.S.C § 1396a(A)(13)(A).
- (2) **State Plan Amendment** means the document described in the Federal Regulations at 42 C.F.R. § 430.10.
- (3) **State Plan Amendment Rate Committee (SPARC)** means a committee comprised of administrative and executive level staff designated by the Chief Executive Officer for the Oklahoma Health Care Authority. The SPARC facilitates the rate setting process by conducting public hearings at which the public, vendors, and OHCA staff are afforded the opportunity to provide testimony and documented evidence in support of rate recommendations. The SPARC only operates to make recommendations for changes to rates that necessitate a State Plan Amendment. Rates that do not necessitate a State Plan Amendment do not require a hearing.
- (4) **Rate Change** means a change that affects the numerical value of payment from the Medicaid agency to the provider including the application of pre-existing factors that increase or decrease a rate. A Rate Change is not

a method change. Rates found in contracts are excluded from the definition of rate change because they are set consensually in a contract. A method or methodology change, as defined below, is not a rate change.

(5) **Method Change or Methodology Change** means a change to how the rate is calculated, not the end result of the rate. In Medicaid rate setting the application of pre-existing factors many times, results in rate changes. The application of pre-existing factors, even if it results in a different rate is not a method change. A method change occurs when OHCA adds, subtracts or alters the factors used to construct the rate.

(b) **Meeting of the State Plan Amendment Rate Committee (SPARC).** In certain instances the SPARC meets to hold public hearings regarding rates set by the Oklahoma Health Care Authority. Under certain provisions of federal law, the agency is required to hold a public hearing to gather public comment regarding proposed method changes or methodology changes regarding the rates it pays its medical providers.

(1) The SPARC only meets when a method change or methodology change occurs in a rate paid from OHCA to a medical provider.

(2) The SPARC does not meet to establish any contractually set rate to a contractor or a contractually bid rate nor does the SPARC meet to hear rate changes.

(c) **SPARC public hearing process.**

(1) The five person panel conducts an open meeting under the Oklahoma Open Meetings Act.

(2) The proceedings are recorded.

(3) The panel hears agency presentations of proposals for method changes or methodology changes and considers comments of any member of the public who desires to comment upon the rate. The Chairperson controls both the agency presentation of proposals and the presentation of comments on the proposed method change.

(4) The panel votes to approve or disapprove the proposed method change in the open meeting, but may adjourn the meeting to gather further information, if necessary. The panel also may adjourn for legal advice during the proceeding. The OHCA board will vote to approve or disapprove the rate methodology upon approval by the SPARC.

(d) **Composition of the SPARC.** The Chief Executive Office appoints OHCA officials to serve on the SPARC. Officials may consist of other state agency employees whose agencies assist in the administration of the Medicaid State Plan.

SUBCHAPTER 5. COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973 [REVOKED]

317:1-5-1. Purpose [REVOKED]

Section 504 of the Rehabilitation Act of 1973 prohibits any entity receiving federal financial assistance from excluding any individual from participation in benefits or any other form of discrimination in any other program or activity. It is the policy of the Oklahoma Health Care Authority to actively work

to ensure that discriminatory activities of any kind do not occur within any program or activity of the Authority.

317:1-5-2. General prohibitions against discrimination [REVOKED]

Section 504 of the Rehabilitation Act of 1973, states in part: *no qualified individual with disabilities, shall, on the basis of disability, be excluded from participation in, be denied the benefits of, otherwise be subjected to discrimination under any program or activity that receives benefits from federal financial assistance.*

317:1-5-3. Qualified individuals with disabilities [REVOKED]

Section 504 of the Rehabilitation Act, guarantees the civil rights of qualified individuals with disabilities and defines qualified individuals with disabilities to mean: *with respect to employment, an individual with disabilities who, with reasonable accommodation, can perform the essential functions of the job in question; and with respect to services, an individual with disabilities who meets the essential eligibility requirements for the receipt of such services.*

317:1-5-4. Self evaluation by departments for compliance [REVOKED]

Each division within the Authority will evaluate on an on-going basis its current rules and practices to ensure compliance with Section 504 of the Rehabilitation Act of 1973. It is the responsibility of each division to evaluate their programs, activities and employment practices to assure that persons with disabilities have full access. Necessary modifications may be made with the assistance of interested persons, including persons with disabilities. Divisions which determine a problem exists in their area or which desire materials or resources to reasonably accommodate program or service participants or employees with disabilities will coordinate this with the Deputy Administrator or supervisor who administers their area.

317:1-5-5. Preemployment medical examinations [REVOKED]

Preemployment medical examinations are not permitted by Section 504 of the Rehabilitation Act of 1973. However, offers of employment may be conditioned on the results of medical examinations, so long as all entering employees are subjected to such an examination, the results are not used in a discriminatory manner, and all medical records are collected and maintained on separate forms that are accorded strict confidentiality. Prohibitions against preemployment inquiries, or gathered medical or similar information prior to the conditional offering of a job include information solicited through interviews, application forms, letters of recommendation, or any other means. The confidentiality of medical records may not be breached except that:

- (1) Supervisors and managers may be informed regarding restrictions on the work or duties of handicapped and regarding necessary accommodations;

(2) First aid and safety personnel may be informed, when appropriate, if the condition might require emergency treatment; and

(3) Government officials investigating compliance with Section 504 shall be provided relevant information upon request.

SUBCHAPTER 7. COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT OF 1990 [REVOKED]

317:1-7-1. Purpose [REVOKED]

The Americans with Disabilities Act of 1990 (ADA) extends the framework of federal civil rights laws to people with disabilities. It became effective January 26, 1992. The Act expressly prohibits discrimination by state or local agencies against individuals with disabilities, regardless of citizenship status or nationality, in employment, public services, public transportation, public accommodations and telecommunications services. Requirements regarding accessibility to facilities for the disabled in the ADA were adopted from the Architectural Barriers Act of 1968. The ADA is divided into these components:

(1) **Title I—Employment.** Employers may not discriminate against qualified individuals with disabilities. Employers must reasonably accommodate the disabilities of qualified applicants or employees, including modifying work stations and equipment, unless undue hardship would result.

(2) **Title II—Public Services.** State and local governments may not discriminate against qualified individuals with disabilities. Newly constructed state and local government buildings, including transit facilities, must be accessible. Alterations to existing state and local government buildings must be done in an accessible manner. New buses and rail vehicles for fixed route systems must be accessible.

(3) **Title III—Public Accommodations.** Restaurants, hotels, theaters, shopping centers and malls, retail stores, museums, libraries, parks, private schools, day care centers, and other similar places of public accommodation may not discriminate on the basis of disability. Physical barriers in existing public accommodations must be removed if readily achievable. New construction in public accommodations and commercial facilities (non residential facilities affecting commerce) must be accessible.

(4) **Title IV—Telecommunications.** Telephone companies must provide telecommunications relay services for hearing impaired and speech impaired individuals 24 hours per day.

317:1-7-2. Definitions [REVOKED]

The following words and terms, when used in this Subchapter, shall have the following meaning, unless the context clearly indicates otherwise.

"Disability" does not include:

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- (A) sexual behavior disorders;
- (B) compulsive gambling, kleptomania or pyromania;
- (C) psychoactive substance abuse disorders resulting from current illegal use of drugs; or
- (D) homosexuality and bisexuality.

"Drug" means a controlled substance, as defined in Schedules I through V of Section 202 of the Controlled Substances Act [21 U.S.C. 812].

"Equal employment opportunity" means an opportunity to enjoy equal benefits and privileges of employment as are available to an average similarly situated employee without a disability.

"Essential functions" means the fundamental job duties of the employment position the individual with a disability holds or desires. The term does not include the marginal functions of the position.

"Has a record of such impairment" means the individual has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

"Illegal use of drugs" means the use of drugs whose possession or distribution is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration.

"Is regarded as having such an impairment" means:

- (A) has a physical or mental impairment that does not substantially limit major life activities but is treated by a covered entity as constituting such limitation;
- (B) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or
- (C) has none of the impairments defined herein but is treated by a covered entity as having a substantially limiting impairment.

"Major life activities" means functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

"Physical or mental impairment" means:

- (A) any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitor-urinary, hemic and lymphatic, skin, and endocrine; or
- (B) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Qualified individual with a disability" means an individual with a disability who satisfies the requisite skill, experience, education and other job-related requirements of the employment position such individual holds or desires, and who, with or without reasonable accommodation, can perform the essential functions of such position. For purposes of organizational policy, the Authority differentiates between a qualified

person with a disability in the area of employment and a qualified person with a disability in the area of DRS programs. A qualified individual with a disability is one who, with or without reasonable accommodation, can perform the essential functions of the position that the individual holds or desires. For the purposes of the ADA, consideration shall be given to the employer's judgement regarding what functions of a job are essential. If an employer has prepared a written job description before advertising or interviewing applicants for the job, this description shall be considered evidence of the essential functions of the job.

"Reasonable accommodation" means:

- (A) modifications or adjustments to a job application process that enable a qualified applicant with a disability to be considered for the position such qualified applicant desires; or,
- (B) modifications or adjustments to the work environment, or to the manner or circumstances under which the position held or desired is customarily performed, that enable a qualified individual with a disability to perform the essential functions of that position; or,
- (C) modifications or adjustments that enable an employee with a disability to enjoy equal benefits and privileges of employment as are enjoyed by its other similarly situated employees.

"Substantially limits" means:

- (A) unable to perform a major life activity that the average person in the general population can perform; or,
- (B) significantly restricted as to the condition, manner or duration under which an individual can perform a particular major life activity as compared to the condition, manner or duration under which the average person in the general population can perform the same life activity.

317:1-7-3. The Oklahoma Health Care Authority and the Americans with Disabilities Act [REVOKED]

The Oklahoma Health Care Authority complies with the provisions of the ADA by prohibiting discrimination against individuals with disabilities. This prohibition applies to:

- (1) Authority employees and individuals seeking employment. Qualified individuals with disabilities must receive equal consideration in:
 - (A) job application procedures;
 - (B) hiring advancement and discharge proceedings;
 - (C) employee compensation;
 - (D) job training; and
 - (E) other terms, conditions and privileges of employment.
- (2) Authority clients and persons applying for services. Qualified individuals with disabilities must have equal access to all services, programs and activities offered or provided by the Authority.

(A) The Authority may comply with the Act by making its facility more accessible or by redesigning equipment or communication devices subject to the limitation in OAC 317:1-7-7.

(B) More specifically, the Authority may use the following mechanisms to comply with paragraph (2) of this subsection:

- (i) Use auxiliary aids or services as designated in 28 C.F.R. §35.104 such as qualified interpreters, notetakers, transcription services, telephone handset amplifiers, telecommunications devices for deaf persons (TDD's), and brailled materials;
- (ii) The use of assistive technology in the agency grievance process;
- (iii) The availability of the grievance process in an alternate format;
- (iv) The acquisition or modification of equipment or devices;
- (v) The reassignment of services to accessible buildings, home visits, home hearings, or other ways to make its services more deliverable;
- (vi) The use of an advocate, if necessary, to speak for the client; and
- (vii) Other services and actions.

317:1-7-4. Requirement for reasonable accommodation [REVOKED]

All divisions and units within the Oklahoma Health Care Authority are required to make reasonable accommodation to the known physical and mental limitations of otherwise qualified disabled employees, applicants and clients unless it can be demonstrated that the accommodation requested would impose an undue hardship on the operations of the Authority. Employment opportunities may not be denied to qualified disabled individuals if the basis for denial is the need to make reasonable accommodations to that person's physical or mental limitations. An otherwise qualified disabled person who is an applicant or client is not discriminated against because he or she does not meet the eligibility requirements of the program. Reasonable accommodation does not require the creation of new positions or promotion for employees with disabilities. However, reassignment of employees to existing positions may be necessary. Such a reassignment should be at the same grade and salary level and one for which the employee is qualified with or without reasonable accommodation. Once it has been determined that no reasonable accommodation is possible and an employee can not perform his or her job satisfactorily, if a reassignment is not possible and the individual does not desire to apply for disability retirement, the employee may be removed from his or her position for failure to perform if:

- (1) there are no positions available for reassignment or placement; or
- (2) the employee refuses an offer of reassignment or placement.

317:1-7-5. Examples of reasonable accommodation [REVOKED]

(a) Examples of reasonable accommodation include, but are not limited to:

- (1) making facilities used by employees readily accessible to and usable by persons with disabilities, such as making common areas accessible including entrances, hallways, restrooms, cafeterias and lounges;
- (2) job restructuring, part time or modified work schedules, acquisition or modification of equipment and devices and the provision of readers or interpreters;
- (3) for blind and visually impaired employees—rearranging fixtures and supplies, labeling shelves in braille, avoiding clutter in corridors and passageways, use of writing and drawing aids, optical aids such as magnifiers;
- (4) for deaf and hard of hearing employees—shifting of phone answering responsibilities to other employees, use of amplification devices, use of a co-worker for receiving and transmitting communications that require use of the telephone during office conferences;
- (5) for the mentally retarded employees—breaking down other jobs into smaller, simple components and reassigning simple tasks; or reassigning simpler duties from higher level employees; and
- (6) for the physically less mobile—making architectural and other physical accommodations as needed.

(b) Each reasonable accommodation for a disabled employee is to be documented and all documents will be maintained in an appropriate manner within the Personnel Department.

317:1-7-6. Requests for reasonable accommodation [REVOKED]

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

(b) A client requesting reasonable accommodation should be directed to the Office of the General Counsel, Oklahoma Health Care Authority, Suite 124, 4545 N. Lincoln Blvd., Oklahoma City, OK, 73105, or such address in the future which is the official mailing address of the Authority. The General Counsel will confer with the appropriate Director regarding the client's request for accommodation and notify the client of the resolution.

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

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

317:1-7-7. Undue hardship/undue burden [REVOKED]

(a) **Employment.** The responsibility of the Authority to provide a reasonable accommodation to a job applicant or an employee is limited to those situations in which it would not be an undue hardship. Undue hardship means an action requiring significant difficulty or expense; one which is unduly, costly, extensive, substantial, disruptive or that will fundamentally alter the nature of the employment. The concept of undue hardship is not limited to financial difficulty, e.g., when an action would fundamentally alter the nature of the employment position. Whether a particular accommodation will be an undue hardship is determined on a case-by-case basis. Factors to be considered include:

- (1) the nature and cost of the accommodation needed or requested;
- (2) the overall financial resources of the Authority;
- (3) the overall size of the Authority with respect to the number of employees;
- (4) the number, type and location of the Authority facilities;
- (5) the type of operations of the Authority, including composition, structure and functions of the workforce; and
- (6) the impact of the accommodation on the operation of the Authority.

(b) **Programs.** The Authority is required to make its programs accessible when viewed in their entirety. It is not required to provide program access when it would result in a fundamental alteration in the nature of the program or undue financial or administrative burdens. However, if measures to provide full program access would result in a fundamental alteration or undue burdens, the Authority is still required to provide as much program access as possible without resulting in fundamental alteration or undue burdens. Furthermore, the Authority has the obligation to prove that providing program access would result in a fundamental alteration or undue burden and all funding resources must be considered. The decision that fundamental alteration or undue burdens would result must be made by the Administrator of the Authority. The decision must be documented in a written statement including the reasons for reaching the conclusion that fundamental alteration or undue burdens would result.

317:1-7-8. Retaliation or coercion [REVOKED]

Individuals who exercise their rights under the ADA, or who assist others in exercising their rights, are protected from

retaliation or coercion. Prohibited activities include harassment, threats, intimidation, or interference in the exercises of rights under the law.

SUBCHAPTER 9. CIVIL RIGHTS AND NONDISCRIMINATION [REVOKED]

317:1-9-1. Purpose [REVOKED]

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, national origin, sex, age or disability. It is the policy of the Oklahoma Health Care Authority to actively work to ensure that the civil rights of all employees and program participants are protected.

317:1-9-2. Statement of compliance [REVOKED]

The Oklahoma Health Care Authority will administer the programs and will conduct its business, either directly, indirectly or through contractual or other arrangements, in compliance with Title VI of the Civil Rights Act of 1964 and 1991, Title 45, Code of Federal Regulations, Parts 80 and 84 and the Age Discrimination Act of 1975, Part 90.

317:1-9-3. Practices prohibited [REVOKED]

In addition to the prohibition of practices addressed under the ADA, the Authority and any members of its staff, employees, contractees, subcontractees or any other persons associated with the Authority shall not:

- (1) discriminate nor allow any other person associated with the Authority to discriminate based on the grounds of race, color, national origin, sex, age or disability.
- (2) issue or allow to be issued policies, regulations, directives or other public communication which will have the effect of subjecting individuals to discrimination because of their race, color, national origin, sex, age or disability.

317:1-9-4. Administration of programs [REVOKED]

Prior to implementation of any new programs or new methods for providing existing services, the Authority will review all components of such programs or services and prepare a report which will show what impact, if any, the program or services shall have on persons protected by Subchapters 5, 7 and 9 of this Chapter. The Authority will take positive action, consistent with Title VI regulations, ADA, or Section 504 regulations, to overcome the effects of conditions which result or will result in limiting participation in any program by persons protected by these Subchapters.

317:1-9-5. Dissemination of nondiscriminatory information [REVOKED]

The Authority will inform all employees, clients, applicants and the general public that all services, any and all other

benefits under its programs are provided on a nondiscriminatory basis.

**317:1-9-6. Assignment of responsibility
[REVOKED]**

The Authority will take the following actions:

- (1) The Administrator of the Authority will assume full responsibility for compliance with Title VI of the Civil Rights Act of 1964, and Section 504 of the Vocational Rehabilitation Act of 1973.
- (2) The Authority has assigned full compliance responsibility to all department heads of every administrative unit.
- (3) The department heads of every administrative unit will keep and maintain essential records and files relative to Title VI and Section 504.
- (4) The Authority will take positive action, consistent with Title VI regulations or Section 504 regulations, to overcome the effects of conditions which result or have resulted in limited participation in any program by persons of a particular race, color, national origin, sex, age or handicap.

317:1-9-9. Complaints [REVOKED]

- (a) Any person who believes that he/she, or any specific class of person, has been subjected to discrimination in an Authority program subject to Title VI or Section 504 may, personally or by a representative, file a written complaint. Authority personnel will assist the complainant in the writing of the complaint if such assistance is needed. Complaints may be filed with the Authority. The complaint will be brought to the attention of the Administrator or a designated Deputy Administrator. A complaint must be filed no later than 180 days from the date of an alleged discriminatory act. The time for filing may however, be extended by the Administrator or a designated Deputy Administrator.
- (b) Following investigation of the complaint, if the responsible official for the Authority believes discrimination did, in fact occur, necessary action will be taken to correct the discriminatory practice, or to require it to be corrected, and to prevent any recurrence of such discrimination. The Authority will take follow up action to determine that the corrective measures have eliminated the conditions that contributed to the discriminatory act.
- (c) The complainant will be advised in writing within 30 days from the receipt of the complaint as to the findings of the Authority regarding the complaint. In the same written notice the complainant will be advised that if he/she is not satisfied with the decision they may appeal the decision (see OAC 317:2-1 for grievance procedures and process). The Authority will maintain records to show the nature of the complaint, the details of the investigation, and the action taken by the Authority. If the complaint has been found to be valid, the records will indicate the nature of the corrective action taken. All complaint records will be available for review by the Authority or other state or judicial entities to which the complainant may appeal as provided by law.

317:1-9-10. Employment practices [REVOKED]

The Authority, in compliance with 45 CFT 84 Subpart B, affirms that no qualified handicapped person shall, on the basis of handicap, be subjected to discrimination in employment under any program or activity of the Authority. The Authority, in compliance with Title VI of the Civil Rights Act of 1964 affirms that no qualified person shall, on the basis of race, color, national origin, sex, age or disability, be subjected to discrimination in employment under any program or activity of the Authority.

[OAR Docket #10-574; filed 4-9-10]

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

[OAR Docket #10-567]

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- 317:2-1-6. through 317:2-1-13. [AMENDED]
- (Reference APA WF # 09-24)

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Agency rules are revised to include language regarding member and provider appeals processes, specifically concerning the time frames allowed for responses to appeals from the Oklahoma Health Care Authority and the

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Administrative Law Judge. Additionally, the rule revision clarifies the process for administrative sanction appeals and the process for provider suspension or termination. Clarification of the rules process is needed to ensure unnecessary legal action by SoonerCare members or providers due to misinterpretation of the rules.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 MAY 13, 2010:

317:2-1-1. Purpose

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

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

Other grievance procedures and processes include those set out in OAC 317:2-1-7 [~~Surveillance, Utilization and Review System (SURS) and (Program Integrity Audits/Reviews Appeals)~~]; OAC 317:2-1-8 (Nursing Home Provider Contract Appeals); OAC 317:2-1-9 [~~OHCA's Designated Agent's Appeal Process for Behavioral Health QIO Services~~]; OAC 317:2-1-10 (Drug Rebate Appeal Process); OAC 317:2-1-11 [Medicaid Drug Utilization Review Board (DUR) Appeal Process]; and OAC 317:2-1-12 (For Cause Provider Contract Suspension/Termination Appeals Process).

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

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

(1) If a provider disagrees with a decision of ~~the SURS or Program Integrity Audit/Review~~ including statewide surveillance and utilization control program appeals, which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision to the State Medicaid Director.

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

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

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

(4) The appeal will be forwarded to the OHCA Legal Services Division by the docket clerk for distribution to the members of the subcommittee and for preparation of the OHCA's case. A subcommittee of the MAC will be formed and render a recommendation to the State Medicaid Director.

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

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

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

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

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

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

(1) If a nursing home provider's contract is terminated, non-renewed or denied prior to the action's effective date, the provider will be afforded an informal reconsideration in accordance with ~~42 C.F.R. 431.154~~ 42 C.F.R. 421.153.

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

(3) The provider will have ~~20~~ 60 days to respond to the notice unless there is a finding of immediate jeopardy or a determination that the facility's SoonerCare certification

has been cancelled prior to 60 days. The response should outline the reasons why the Authority's OHCA's decision to terminate, non-renew, or deny the contract is wrong. The response by the provider must include a detailed position addressing the findings set out in the Authority's OHCA's letter. ~~The provider may request an extension of the 20 day limit if "good cause" exists that prevents the provider from refuting the findings in 20 days. A finding of "good cause" is in OHCA's discretion. In the event that less than a 60 day notice is provided for either reason stated above, the provider will be afforded a notice in as much time before decertification as possible.~~

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

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

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

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

317:2-1-9. OHCA's Designated Agent's appeal process for Behavioral Health services QIO Decisions

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

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

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

(1) The process begins at the end of each calendar quarter when the Authority will mail OHCA mails a copy of the State's past quarter's utilization data to the manufacturer. Utilization data and a billing for rebates will be

mailed to the manufacturer within 60 days after the end of each quarter. It is this data which dictates the application of the federal drug rebate formula.

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

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

- (A) pay the same amount as billed by the state with the quarterly utilization date;
- (B) pay an amount which differs from the amount billed by the state with the utilization data and send disputed data information;
- (C) pay nothing and send no disputed data information;
- (D) pay nothing and send disputed data information.

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

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

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

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

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

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

- (A) receipt of the rebate, if any;
- (B) receipt of the dispute;
- (C) a statement regarding the interest amount; and
- (D) a statement regarding the appeal rights of the manufacturer with a copy of the appeal form.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This Section explains the appeals process for providers whose ~~Medicaid~~ SoonerCare contracts have been suspended/terminated by the OHCA for cause. Those providers whose contracts have been affected by other OHCA actions cannot request an appeal of those measures. Contracts terminated or suspended for cause are either timed terminations (30, 60, or 90 day) or immediate terminations/suspensions. Paragraphs (1) and (2) apply to timed terminations/suspensions and paragraph (3) applies to immediate terminations.

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

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

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

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

(C) Notice of suspension or termination.

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

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

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

- (I) the reasons for the decision;
- (II) the effective date of the suspension or termination of the contract;
- (III) the medical services provider's right to request a post-suspension or termination hearing; and
- ~~(IV) the earliest date in which the agency will accept a request for reinstatement; and~~
- ~~(V-IV) the requirements and procedures for reinstatement.~~

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

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

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

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

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

(3) **Notice of immediate suspension or termination.** The process below will be followed in the event of an immediate suspension or termination:

(A) A notice described in paragraph (1)(A) will be sent to the provider, except there is no right to review prior to an immediate termination or suspension.

(B) A post suspension termination review will be conducted in accordance with paragraph (2) above.

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

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

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

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

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

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

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

[OAR Docket #10-567; filed 4-9-10]

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

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Rule revisions are needed to clarify member responsibilities regarding the reporting of third party liability, utilization of private insurance and notification to medical providers of SoonerCare coverage. Implementation of this rule will reduce the amount of federal and state dollars utilized for healthcare, reducing the burden of providing costly healthcare from strained State Agency budgets and shifting it to third party resources.

CONTACT PERSON:

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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 MAY 13, 2010:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-24. Third party resources liability

As the Medicaid Agency, OHCA is ~~the last resource for payment~~ the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. ~~One exception~~ Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. Guidance for third party liability under the Insure Oklahoma program is found in OAC 317:45, Oklahoma Employer and Employee Partnership for Insurance Coverage.

(1) ~~If the children or other individuals in a case are covered a member has coverage~~ by an absent parent's insurance program or any other policy holder, ~~the that~~

insurance resource must be used prior to filing a Medicaid SoonerCare claim. This includes Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and any other insuring arrangement ~~if the covered individuals live in the coverage area. Clients covered by insurance, who elect to use providers who do not have a contract with their insurance company, arrangements that provide a member access to healthcare. Members must comply with all requirements of their primary insurance as well as SoonerCare requirements in order to take advantage of both coverages. For example, a member must comply with the network restrictions of both the primary and SoonerCare plans as well as prior authorization requirements. If the member does not comply with the requirements of the primary plan, he/she will be responsible for the charges incurred. Denials by private insurance companies because the recipient member did not secure a preauthorization to or use a non-participating participating provider is not a sufficient reason for Medicaid SoonerCare to make payment. When a If the provider is aware of private insurance or liability, a claim must first be filed with that source. When private insurance information is known to the OHCA, the REVS System or commercial swipe care vendor will reflect an insurance indicator eligibility verification system will reflect that information. If payment is denied from another source by the primary insurance, except as stated above, the provider should must attach the Explanation of Benefits (EOB), stating the reason for the denial, to the claim submitted to the Fiscal Agent. When payment is received from another source, that payment amount should must be shown reflected on the claim form filed with that Fiscal Agent.~~

(2) It is possible that other resources are available but are unknown to OHCA. Providers ~~should will~~ routinely question ~~Medicaid patients SoonerCare members~~ to determine whether any other resources are available. In some instances, coverage may not be obvious, for example, the ~~patient member~~ may be covered by a policy on which he/she is not the subscriber (e.g., a child whose absent parent maintains medical and hospital coverage).

(3) ~~In the event If~~ the provider receives payment from another source after OHCA has made payment, it is necessary that the provider reimburse OHCA for the Title XIX (Medicaid) payment. The provider may retain ~~that portion of the other the primary insurance~~ payment, if any, that represents payment for services that are not covered services under Medicaid SoonerCare. By accepting the ~~Authority's OHCA's~~ payment, the provider agrees to accept the ~~reasonable charge~~ it as payment in full and, therefore, cannot retain any portion of other resource money as payment for reduced charges on covered services. Other than SoonerCare copayments, a provider cannot bill a member for any unpaid portion of the bill or for a claim that is not paid because of provider administrative error. If, after reimbursing OHCA and retaining a portion of the other payment in satisfaction of any non-covered services there is money remaining, it must be refunded to the ~~patient member~~.

~~(4) There are instances where insurance companies have made payment by a single check for both the hospitalization service and the physician's fees, and the entire amount has been credited to one provider, rather than being distributed according to the type of coverage under the policy. The hospital must show credit for the respective amounts against the billed charges. This calculation is subject to final review and audit by the Fiscal Agent or OHCA. If a member is covered by a private health insurance policy or plan, he/she is required to inform medical providers of the coverage, including:~~

- ~~(A) provision of applicable policy numbers;~~
- ~~(B) assignment payments to medical providers;~~
- ~~(C) provision of information to OHCA of any coverage changes; and~~
- ~~(D) release of money received from a health insurance plan to the provider if the provider has not already received payment or to the OHCA if the provider has already been paid by the OHCA.~~

~~(5) If the patient is a recipient of Medical Assistance only, it is understood that the payment received from OHCA represents full payment for services rendered. In those instances where the patient has excess income, and/or insurance, payment will be made by OHCA for the difference between the amount paid by insurance and/or spenddown and the allowable charge, if any. Members are responsible for notifying their providers of the intent to make application for SoonerCare coverage and of any retroactive eligibility determinations. Members may be responsible for any financial liability if they fail to notify the provider of the eligibility determinations and as a result, the provider is unable to secure payment from OHCA.~~

~~(6) For claims processed by the Fiscal Agent, the excess shown on the OHCA Notification of Eligibility will be applied to providers' claims on a first in basis. When a provider receives notice on the Detail of Remittance that spenddown was applied to his/her claim, the amount shown may be collected from the patient. The patient will also receive a notice indicating the name of the provider and the amount of spenddown applied. Members must present evidence of SoonerCare and any other health insurance coverage to a medical provider each time services are requested. Members may be responsible for any financial liability if they fail to furnish the necessary information before the receipt of services and as a result, the provider is unable to secure payment from OHCA.~~

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

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May 13, 2010

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Superseded rules:

Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-27. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 110. Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us)
317:30-5-1091. [AMENDED]

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09-1212

(Reference APA WF # 09-16)

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rule revisions are needed to add Indian Health Service Facilities, Tribally Operated Facilities and Urban Indian Clinics as distant site providers under the telemedicine delivery system, allowing segments of the Native American population in rural areas access to specialty healthcare services. Additionally, this rule includes public health nursing as an allowable service available to qualifying individuals in the Native American population on a statewide basis. Without this rule revision, Native American SoonerCare members may be denied access to critical nursing and specialty care services.

CONTACT PERSON:

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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 MAY 13, 2010:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-27. Telemedicine

(a) **Applicability and scope.** The purpose of this Section is to implement telemedicine policy that improves access to health care services by enabling the provision of medical specialty care in rural or underserved areas to meet the needs of members and providers alike, while complying with all applicable federal and state statutes and regulations. Telemedicine services are not an expansion of SoonerCare covered services but an option for the delivery of certain covered services. SoonerCare views telemedicine no differently than an office visit or outpatient consultation. However, if there are technological difficulties in performing an objective through medical assessment or problems in member's understanding of telemedicine, hands-on-assessment and/or care must be provided for the member. Quality of health care must be maintained regardless of the mode of delivery.

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

(1) **"Certified or licensed health care professional"** means an individual who has successfully completed a prescribed program of study in any variety of health fields and who has obtained an Oklahoma state license or certificate indicating his or her competence to practice in that field.

(2) **"Distant site"** means the site where the specialty physician/practitioner providing the professional service is located at the time the service is provided via audio/video telecommunications.

(3) **"Interactive telecommunications"** means multimedia communications equipment that includes, at a minimum, audio/video equipment permitting two-way, real-time or near real-time service or consultation between the member and the practitioner.

(4) **"Originating site"** means the location of the SoonerCare member at the time the service is being performed by a contracted provider via audio/video telecommunications.

(5) **"Rural area"** means a county with a population of less than 50,000 people.

(6) **"Store and forward"** means the asynchronous transmission of medical information to be reviewed at a later time. A camera or similar device records (stores) an

image(s) that is then sent (forwarded) via telecommunications media to another location for later viewing. The sending of x-rays, computed tomography scans, or magnetic resonance images are common store and forward applications. The original image may be recorded and/or forwarded in digital or analog format and may include video "clips" such as ultrasound examinations, where the series of images that are sent may show full motion when reviewed at the receiving location.

(7) **"Telehealth"** means the use of telecommunications technologies for clinical care (telemedicine), patient teaching and home health, health professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system.

(8) **"Telemedicine"** means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the real-time or near real-time and in the physical presence of the member.

(9) **"Telemedicine network"** means a network infrastructure, consisting of computer systems, software and communications equipment to support telemedicine services.

(10) **"Underserved area"** means an area that meets the definition of a medically underserved area (MUA) or medically underserved population (MUP) by the U.S. Department of Health and Human Services (HHS).

(c) **Coverage.** SoonerCare coverage for telemedicine technology is limited to consultations, office visits, individual psychotherapy, psychiatric diagnostic interview examinations and testing, mental health assessments and pharmacologic management.

(1) An interactive telecommunications system is required as a condition of coverage.

(2) Coverage for telemedicine services is limited to members in rural areas, underserved areas, or geographic areas where there is a lack of medical/psychiatric/mental health expertise locally.

(3) Office and outpatient visits that are conducted via telemedicine are counted toward the applicable benefit limits for these services.

(4) Authorized originating sites are:

(A) The office of a physician or practitioner;

(B) A hospital;

(C) A school;

(D) An outpatient behavioral health clinic;

(E) A critical access hospital;

(F) A rural health clinic (RHC);

(G) A federally qualified health center (FQHC); or

(H) An Indian Health Service facility, a Tribal health facility or an Urban Indian clinic (I/T/U).

(5) Authorized distant site specialty ~~physicians and practitioners~~ providers are contracted:

(A) Physicians;

(B) Advanced Registered Nurse Practitioners;

(C) Physicians Assistants;

(D) Genetic Counselors;

(E) Licensed Behavioral Health Professionals; ~~and~~

- (F) Dieticians; and
 - (G) I/T/U's with specialty service providers as listed in (A) through (F) above.
- (d) **Non-covered services.** Non-covered services include:
- (1) Telephone conversation;
 - (2) Electronic mail message; and
 - (3) Facsimile.
- (e) **Store and forward technology.** SoonerCare covers store and forward technology for applications in which, under conventional health care delivery, the medical service does not require face-to-face contact between the member and the provider. Examples include teleradiology, telepathology, fetal monitor strips, as well as physician interpretation of electrocardiogram and electroencephalogram readings that are transmitted electronically. SoonerCare does not consider these services telemedicine as defined by OHCA and will not reimburse an originating site fee for these services.
- (f) **Conditions.** The following conditions apply to all services rendered via telemedicine.
- (1) Interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the SoonerCare member. As a condition of payment the member must be present and participating in the telemedicine visit.
 - (2) Only telemedicine services provided utilizing an OHCA approved network are eligible for reimbursement.
 - (3) For SoonerCare reimbursement, telemedicine connections to rural areas must be located within Oklahoma and the health providers must be licensed in Oklahoma or practice at an I/T/U.
 - (4) The telemedicine equipment and transmission speed must be technically sufficient to support the service billed. If a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality for decision making. Staff involved in the telemedicine visit need to be trained in the use of the telemedicine equipment and competent in its operation.
 - (5) An appropriate certified or licensed health care professional at the originating site is required to present the member to the physician or practitioner at the distant site and remain available as clinically appropriate.
 - (6) The health care practitioner must obtain written consent from the SoonerCare member that states they agree to participate in the telemedicine-based office visit. The consent form must include a description of the risks, benefits and consequences of telemedicine and be included in the member's medical record.
 - (7) If the member is a minor child, a parent/guardian must present the minor child for telemedicine services unless otherwise exempted by State or Federal law. The parent/guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.
 - (8) The member retains the right to withdraw at any time.
 - (9) All existing confidentiality protections apply.
 - (10) The member has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.
 - (11) There will be no dissemination of any member images or information to other entities without written consent from the member.
- (g) **Reimbursement.**
- (1) A facility fee will be paid to the originating site when the appropriate telemedicine facility fee code is used.
 - (A) Hospital outpatient: When the originating site is a hospital outpatient department, payment for the originating site facility fee will be paid according to the SoonerCare fee schedule.
 - (B) Hospital inpatient: For hospital inpatients, payment for the originating site facility fee will be paid outside the Diagnostic Related Group (DRG) payment.
 - (C) FQHCs and RHCs: The originating site facility fee for telemedicine services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee is paid separately from the center or clinic all-inclusive rate.
 - (D) Facilities of the Indian Health Service, tribal facilities or Urban Indian Clinics: When an I/T/U serves as the originating site, the originating site facility fee is reimbursed outside the OMB rate.
 - (E) Physicians'/practitioners' offices: When the originating site is a physician's office, the originating site facility fee will be paid according to the SoonerCare fee schedule. If a provider from the originating site performs a separately identifiable service for the member on the same day as telemedicine, documentation for both services must be clearly and separately identified in the member's medical record.
 - (2) Services provided by telemedicine must be billed with the appropriate modifier. Only the portion of the telemedicine service rendered from the distant site is billed with the modifier.
 - (3) If the technical component of an X-ray, ultrasound or electrocardiogram is performed at the originating site during a telemedicine transmission, the technical component and a telemedicine facility fee are billed by the originating site. The professional component of the procedure and the appropriate visit code are billed by the distant site.
 - (4) Post payment review may result in adjustments to payment when a telemedicine modifier is billed inappropriately or not billed when appropriate.
 - (5) The cost of telemedicine equipment and transmission is not reimbursable by SoonerCare.
- (h) **Documentation.**
- (1) Documentation must be maintained at the originating and the distant locations to substantiate the services provided.
 - (2) Documentation must indicate the services were rendered via telemedicine, the location of the originating

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and distant sites, and which OHCA approved network was used.

(3) All other SoonerCare documentation guidelines apply to the services rendered via telemedicine. Examples include but are not limited to:

- (A) Chart notes;
- (B) Start and stop times;
- (C) Service provider's credentials; and
- (D) Provider's signature.

(i) **Telemedicine network standards.** In order to be an approved telemedicine network, an applicant must be contracted with the OHCA and meet certain technical and privacy standards stated within the contract in order to ensure the highest quality of care.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN INDIAN CLINICS(I/T/US)

317:30-5-1091. Definition of I/T/U services

(a) As described in Title 42 of the Code of Federal Regulations (CFR) 136.11(a), the I/T/U services may include hospital and medical care, dental care, public health nursing and preventive care (including immunizations), and health examination of special groups such as school children.

(b) Further, Title 42 CFR 136.11(c) allows that the scope and availability of I/T/U services will depend upon the resources of the facility.

(c) I/T/U services may be covered when furnished to a patient at the clinic or other location, including a mobile clinic, or the patient's place of residence.

(d) I/T/U outpatient encounters include but are not limited to:

- (1) Physicians' services and supplies incidental to a physician's services;
- (2) Within limitations as to the specific services furnished, a doctor of dentistry or oral surgery, a doctor of optometry, or a doctor of podiatry [Refer to Section 1861(r) of the Act for specific limitations];
- (3) The services of a resident as defined in OAC 317:25-7-5(4) who meets the requirements for payment under SoonerCare and the supplies incidental to a resident's services;
- (4) Services of advanced practice nurses (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;
- (5) Services and supplies incidental to the services of APNs and PAs (including services furnished by certified nurse midwives);
- (6) Public health nursing services include but are not limited to services in the following areas:

- (A) Phlebotomy;

- (B) Wound care;
 - (C) Public health education;
 - (D) Administration of immunizations;
 - (E) Administration of medication;
 - (F) Child health screenings meeting EPSDT criteria;
 - (G) Prenatal, newborn and postpartum assessments, including case management services for first time mothers; and
 - (H) General health assessments and management of conditions such as tuberculosis, diabetes and hypertension.
- (67) Visiting nurse services to the homebound;
- (78) Behavioral health professional services and services and supplies incidental to the services of LBHPs; and
- (89) Dental services.

[OAR Docket #10-563; filed 4-9-10]

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

[OAR Docket #10-557]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-61. [NEW]

(Reference APA WF # 09-04)

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 440.180

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Subchapter 3. General Provider Policies
Part 3. Medical Program Information
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December 3, 2009

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27 Ok Reg 449

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09-1518

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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rules are revised to include an agency model for administration and operation of a program for self-direction. All programs implementing the self-direction option must adhere to the requirements of this policy. Self-direction is a method of service delivery that allows members, who qualify for institutional care, to determine what supports and services they need to live successfully in a home and community based setting.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 MAY 13, 2010:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-61. Self-Directed Services

(a) **Agency Model.** The OHCA Self-Direction Model is an overarching set of guidelines to standardize policy for all self-directed service programs operated through the SoonerCare program. The following rules set forth minimum requirements to which all self-directed service programs must adhere. As the infrastructure for new or renewing self-direction programs is developed, the following elements will serve as a template for the programs to follow.

(b) **Definitions.**

- (1) **"Financial Management Service"** (FMS) is defined as a fiscal intermediary that provides at a minimum, accounting, billing and payroll services on behalf of the member, for reimbursement through the OHCA.
- (2) **"Program"** is defined as a set of benefits offered to a specific population of SoonerCare members (the program can be operated by the OHCA or another agency partner).
- (3) **"Rendering provider"** is defined as the actual deliverer of allowable goods or services.
- (4) **"Self-Direction"** is defined as a method of service delivery that allows members to determine what supports and services they need to live successfully in a home and community based setting.

(c) **Member processes.** The program will establish, at a minimum, the following processes for members who choose to self direct:

(1) The program will establish requirements for member eligibility including a process for evaluating member needs. These requirements will also include a process for denial of eligibility.

(2) The program will determine detailed benefit packages and will specify allowable goods and services available to members.

(3) The program will define the member's options for self-direction. These will vary according to the approved benefit package. At a minimum, the options for self-direction will include:

- (A) training for members that is appropriate to the care provided;
- (B) utilization of a Financial Management Service (FMS) for purposes of payroll and payment to vendors. The FMS may also provide other services as determined by the individual program;
- (C) detailed description demonstrating that members have freedom of choice under all levels of self-direction options offered;
- (D) for security and auditing purposes, the program will design and implement a system for verification of services in accordance with CMS standards; and
- (E) designate methods of outreach to inform members and potential members of available services, emergency procedures, concerns and general information.

(d) **Provider processes.** The program will establish minimum criteria for providers. These criteria will be specific to provider type and at a minimum include:

- (1) training appropriate to each level of service to be provided;
- (2) credentialing or licensure by a recognized state agency, if applicable to the provider type and duties;
- (3) establish and specify an appropriate provider type and specialty code to apply to approved providers for the program. This provider type and specialty code must meet requirements for data integrity and auditing purposes.
- (4) specify the minimum and maximum allowed rates for providers by provider type. Rates will be governed by guidelines determined by the program within approved limits and budget allowances. The program will also establish an appropriate methodology for fees paid to the FMS for administration of payroll, accounting and any other contracted duties;
- (5) provider contracts with the OHCA or with a contracted agency operating as an Organized Health Care Delivery System (OHCDS);
- (6) establish a provider enrollment process. At a minimum, the process shall include the following:

(A) all rendering providers will be entered into the OHCA provider tracking system and given a unique rendering provider ID number. In instances of an Organized Health Care Delivery System, the OHCDS will be considered the rendering provider for purposes of enrollment.

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(B) the FMS will be entered into the OHCA provider tracking system and given a unique provider ID number as the billing or group provider;

(C) all rendering providers must pass a background investigation prior to employment.

(e) **Provider selection & outreach.**

(1) The program will identify methods for assisting members in provider selection.

(2) The program will determine processes for informing and recruiting providers.

(3) The program will develop processes for provider communication to inform providers of procedures, concerns and general information.

(f) **Claims filing process.**

(1) The program will ensure claims are billed to the OHCA from the FMS and processed through the OHCA claims tracking system.

(2) The program will have appropriate procedure codes with necessary modifiers for each benefit in the program.

(3) Procedure codes must provide sufficient detail to allow for claims identification in the OHCA claims tracking system (all claims must have at a minimum a billing, rendering and pay to).

(g) **Claims payment processes for providers, agents and agencies.** Payments for rendering providers must be paid through an FMS. The program will establish the payment options for the FMS to utilize for paying the rendering providers.

(h) **Payment processes for alternative goods & services.** Some programs may allow for non-traditional services and alternative sources for goods with approval. The program shall determine the process for the payment of these alternative benefits with the following restrictions:

(1) identify appropriate procedure codes with necessary modifiers to allow claims to be processed and identified in the OHCA claims tracking system;

(2) prior authorization for alternative goods and services and payment made directly to the vendor. No payment for good or services will be made to the member.

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Subchapter 3. General Provider Policies

Part 5. Eligibility

317:30-3-80. [REVOKED]

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26 Ok Reg 3028

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09-1215

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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rule revisions are needed to alleviate confusion and make rules consistent concerning prior authorization for oxygen and oxygen equipment. Specific DME policy already addresses that prior authorization is not required as long as providers maintain a fully completed certificate of medical necessity.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 MAY 13, 2010:

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

[OAR Docket #10-568]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. General Provider Policies

Part 5. Eligibility

317:30-3-80. [REVOKED]

(Reference APA WF # 09-26)

AUTHORITY:

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 5. ELIGIBILITY

317:30-3-80. Physician's prescription for appliances, prostheses, and/or medical equipment and medical suppliers request for prior authorization [REVOKED]

~~Request prior authorization for oxygen concentrators, appliances, prostheses, medical equipment and medical supplies via CC 17, Physicians Prescription and Authorization, in triplicate. Section I is completed by the physician, who forwards the original and one copy of the form to the medical supplier. The medical supplier completes Section II and forwards the~~

original to OHCA, Special Health Care Needs Unit. No item will be authorized unless prescribed by the physician. Some items also require a Certificate of Medical necessity.

[OAR Docket #10-568; filed 4-9-10]

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

[OAR Docket #10-560]

RULEMAKING ACTION:

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RULES:

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-1. [AMENDED]

Part 69. Certified Registered Nurse Anesthetists

317:30-5-605. [AMENDED]

317:30-5-607. [AMENDED]

317:30-5-608. [REVOKED]

317:30-5-609. [REVOKED]

317:30-5-610. [REVOKED]

317:30-5-611. [AMENDED]

Part 70. Anesthesiologist Assistants [NEW]

317:30-5-612. [NEW]

317:30-5-613. [NEW]

317:30-5-614. [NEW]

317:30-5-615. [NEW]

(Reference APA WF # 09-09)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 3201 through 3208 of Title 59 of Oklahoma Statutes

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Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-1. [AMENDED]

Part 69. Certified Registered Nurse Anesthetists

317:30-5-605. [AMENDED]

317:30-5-607. [AMENDED]

317:30-5-608. [REVOKED]

317:30-5-609. [REVOKED]

317:30-5-610. [REVOKED]

317:30-5-611. [AMENDED]

Part 70. Anesthesiologist Assistants [NEW]

317:30-5-612. [NEW]

317:30-5-613. [NEW]

317:30-5-614. [NEW]

317:30-5-615. [NEW]

Gubernatorial approval:

April 28, 2009

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26 Ok Reg 1759

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09-905

(Reference APA WF # 09-09)

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rule revisions are needed to comply with the Oklahoma Anesthesiologist Assistant Act found at 59 Okla. Stat. 3201-3208. The Act allows for the licensing of Anesthesiologist Assistants (AA) which thus enables them to contract with the Oklahoma Health Care Authority to provide crucial and necessary services to SoonerCare members.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 MAY 13, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-1. Eligible providers

To allow patients free choice of physicians, the Oklahoma Health Care Authority (OHCA) recognizes all licensed medical and osteopathic physicians as being eligible to receive payment for compensable medical services rendered in behalf of a person eligible for such care in accordance with the rules and regulations covering the Authority's medical care programs. Payment will be made to fully licensed physicians who are participating in medical training programs as students, interns, residents, or fellows, or in any other capacity in training for services outside the training setting and are not in a duplicative billing situation. In addition, payment will be made to the employing facility for services provided by physicians who meet all requirements for employment by the Federal Government as a physician and are employed by the Federal Government in an IHS facility or who provide services in a 638 Tribal Facility. Payment will not be made to a provider who has been suspended or terminated from participation in the program.

(1) Payment to physicians under Medicaid and SoonerCare is made for services clearly identifiable as personally rendered services performed on behalf of a specific patient. There are no exceptions to personally rendered services unless specifically set out in coverage guidelines.

(2) Payment is made to the attending physician in a teaching medical facility for compensable services when

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he/she signs as claimant, and renders personal and identifiable services to the patient in conformity with Federal regulations. ~~Payment will be made to a physician for supervising the services of a CRNA unless the CRNA bills directly.~~

(3) ~~Payment is made to a physician for medically directing the services of a Certified Registered Nurse Anesthetist (CRNA) at a rate of 50% of the physician allowable for anesthesia services.~~

(4) ~~Payment is made to a physician for the direct supervision of an Anesthesiologist Assistant (AA) at a rate of 50% of the physician allowable for anesthesia services. Direct supervision means the on-site, personal supervision by an anesthesiologist who is present in the office, or is present in the surgical or obstetrical suite when the procedure is being performed and who is in all instances immediately available to provide assistance and direction to the AA while anesthesia services are being performed.~~

PART 69. CERTIFIED REGISTERED NURSE ANESTHETISTS

317:30-5-605. Eligible providers

~~Effective for services provided on or after April 1, 1987—~~ Payment is made directly to Certified Registered Nurse Anesthetists (CRNA) for compensable anesthesia services within their scope of practice under state law. The CRNA must be licensed to practice under applicable State Laws state laws. In addition, the CRNA must have a current Memorandum of Agreement provider contract on file with the Oklahoma Health Care Authority (OHCA).

317:30-5-607. Billing instructions

The CRNA is responsible for entering the correct anesthesia procedure code on the appropriate claim form. Anesthesia codes from the Physicians' Current Procedural Terminology or Medicare assigned codes should be used.

- (1) Payment is made only for the major procedure during an operative session.
- (2) All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied. Payment to the CRNA is limited to 80% of the physician allowable for anesthesia services without medical direction using modifier QZ and 50% of the physician allowable when services are provided under the medical direction of an anesthesiologist using modifier QX.
- (3) Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. Additional payment can be made when applicable for extremes of age, total body hypothermia and controlled hypertension.
- (4) All other qualifying circumstances, i.e., physical status, emergency, etc., have been structured into the total allowable for the procedure.
- (5) Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by the Authority's Medical Consultants.

(6) Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

317:30-5-608. Elective sterilizations [REVOKED]

~~(a) Payment is made to certified registered nurse anesthetists for elective sterilizations performed in behalf of eligible individuals if all of the following circumstances are met:~~

- ~~(1) The patient must be at least 21 years of age at the time the consent form is signed;~~
- ~~(2) The patient must be mentally competent;~~
- ~~(3) A properly completed Federally mandated consent for sterilization form is attached to the claim, and~~
- ~~(4) The form is signed and dated at least 30 days, but not more than 180 days prior to the surgery.~~

~~(b) A copy of the consent for sterilization should be obtained from the surgeon or the hospital and attached to the claim form.~~

317:30-5-609. Hysterectomies [REVOKED]

~~(a) A hysterectomy performed for purposes of sterilization or family planning is not compensable.~~

~~(b) Payment is made to certified registered nurse anesthetists for therapeutic hysterectomies only when one of the following circumstances is met:~~

- ~~(1) A properly completed hysterectomy acknowledgement is attached to the claim form. The acknowledgement must clearly state that the patient or her representative was informed, orally and in writing, prior to the surgery that she would be rendered permanently incapable of reproduction.~~
- ~~(2) The 30 day waiting period which applies to elective sterilizations does not apply to therapeutic hysterectomies.~~
- ~~(3) The surgeon must certify in writing that the patient was sterile prior to the surgery. The reason for the sterility, i.e., post-menopausal, previous tubal ligation, etc., must be given.~~
- ~~(4) The surgeon must certify that the surgery was performed in an emergency, life endangering situation. The circumstances must be given.~~

~~(c) Documentation to meet one of the situations in (b) of this Section should be obtained from the surgeon or the hospital and attached to the claim form.~~

317:30-5-610. Abortions [REVOKED]

~~(a) Payment is made only for abortions in those instances where the abortion is necessary due to a physical disorder, injury or illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or where the pregnancy is the result of an act of rape or incest. Medicaid coverage for abortions to terminate pregnancies that are the result of rape or incest will only be provided as long as Congress considers abortions in cases of rape or incest to be medically necessary services and federal financial participation is available specifically for these services.~~

(1) For abortions necessary due to a physical disorder, injury or illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, the physician must certify in writing that the abortion is being performed due to a physical disorder, injury or illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. The mother's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.

(2) For abortions in cases of rape or incest, there are two requirements for the payment of a claim. First, the patient must fully complete the Patient Certification for Medicaid Funded Abortion. Second, the patient must have made a police report or counselor's report of the rape or incest.

(b) The Oklahoma Health Care Authority performs a "look behind" procedure for abortion claims paid from Medicaid funds. This procedure will require that this Agency obtain the complete medical records for abortions paid under Medicaid. On a post payment basis, this Authority will obtain the complete medical records on all claims paid for abortions.

(c) Claims for spontaneous abortions, including dilation and curettage, do not require certification. The following situations also do not require certification:

- (1) If the physician has not induced abortion, counseled or otherwise collaborated in inducing the abortion; and
(2) If the process has irreversibly commenced at the point of the physician's medical intervention.

(d) Claims for the diagnosis "incomplete abortion" require medical review.

(e) The appropriate diagnosis codes should be used indicating spontaneous abortion, etc., otherwise the procedure will be denied.

317:30-5-611. Payment methodology

When payment is made directly to a CRNA, such payment will be made at the rate of 80 percent of the allowable for anesthesia services. Payment to the CRNA is limited to 80% of the physician allowable for anesthesia services performed without medical direction and 50% of the physician allowable when services are provided under the medical direction of a licensed physician.

PART 70. ANESTHESIOLOGIST ASSISTANTS

317:30-5-612. Eligible providers

Payment is made directly to Anesthesiologist Assistants (AA) for compensable anesthesia services within their scope of practice under state law. The AA must be licensed to practice under applicable state laws. In addition, the AA must have a current provider contract on file with the Oklahoma Health Care Authority (OHCA).

317:30-5-613. Coverage by category

Payment is made to Anesthesiologist Assistants as set forth in this Section.

- (1) Adults. Payment is made for the administration of anesthesia to adults within the scope of the Authority's medical programs, provided the services are reasonable and necessary for the treatment of illness or injury, or to improve the functioning of a malformed body member.
(2) Children. Coverage for children is the same as for adults.
(3) Individuals eligible for Part B of Medicare. Payment is made utilizing the Medicaid allowable for comparable services.

317:30-5-614. Billing instructions

The AA is responsible for entering the correct anesthesia procedure code on the appropriate claim form. Anesthesia codes from the Physicians' Current Procedural Terminology or Medicare assigned codes should be used.

- (1) Payment is made only for the major procedure during an operative session.
(2) All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied. Payment is made to an AA for services provided under the direct supervision of a licensed anesthesiologist and is limited to 50% of the physician allowable using modifier QX.
(3) Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. Additional payment can be made when applicable for extremes of age, total body hypothermia and controlled hypertension.
(4) All other qualifying circumstances, i.e., physical status, emergency, etc., have been structured into the total allowable for the procedure.
(5) Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by the Authority's Medical Consultants.
(6) Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

317:30-5-615. Payment methodology

Payment to the AA is limited to 50% of the physician allowable for anesthesia services.

[OAR Docket #10-560; filed 4-9-10]

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

[OAR Docket #10-580]

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RULES:

Subchapter 5. Individual Providers and Specialties
Part 10. Bariatric Surgery
317:30-5-137. [AMENDED]
317:30-5-137.1. [NEW]
317:30-5-137.2. [NEW]
317:30-5-138. [REVOKED]
317:30-5-139. [REVOKED]
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N/A

ANALYSIS:

Bariatric surgery rules are revised to re-order the prior authorization process in policy and provide further clarification of the prior authorization process. This revision effectively re-orders policy to present member candidacy guidelines prior to presenting coverage guidelines. This will facilitate the current prior authorization process and encourage providers to request a member candidacy prior authorization before requesting the prior authorization for the surgery. These revisions are not changing the prior authorization process, only reinforcing the current process.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 MAY 13, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 10. BARIATRIC SURGERY

317:30-5-137. Eligible providers to perform bariatric surgery

The Oklahoma Health Care Authority (OHCA) covers bariatric surgery under certain conditions as defined in this section. Bariatric surgery is not covered for the treatment of obesity alone. To be eligible for reimbursement, for bariatric surgery providers must be certified by the American College of Surgeons (ACS) as a Level I Bariatric Surgery Center or certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (BSCO) or the surgeon and facility are currently participating in a bariatric surgery quality assurance program and a clinical outcomes assessment program review. All qualifications must be met and approved by the OHCA. Bariatric surgery facilities and their providers must be contracted with OHCA.

317:30-5-137.1. Member candidacy

Documentation must be submitted to the OHCA prior authorization unit prior to beginning any treatment program to ensure all requirements are met and the member is an appropriate candidate for bariatric surgery. This is the first of two prior authorizations required to approve a member for bariatric surgery. To be considered, members must meet the following candidacy criteria:

- (1) be between 18 and 65 years of age;
- (2) have body mass index (BMI) of 35 or greater;
- (3) be diagnosed with one of the following:
 - (A) diabetes mellitus;
 - (B) degenerative joint disease of a major weight bearing joint(s). The member must be a candidate for joint replacement surgery when optimal weight loss is achieved; or
 - (C) a rare co-morbid condition in which there is medical evidence that bariatric surgery is medically necessary to treat such a condition and that the benefits of bariatric surgery outweigh the risk of surgical mortality.
- (4) have presence of obesity that has persisted for at least 5 years;
- (5) have attempted weight loss in the past without successful long term weight reduction, which must be documented by a physician;
- (6) have absence of other medical conditions that would increase the member's risk of surgical mortality or morbidity; and
- (7) the member is not pregnant or planning to become pregnant in the next two years.

317:30-5-137.2. General coverage

(a) After receiving member candidacy prior authorization from OHCA and the determination that member candidacy

requirements are met (see OAC 317:30-5-137.1), the primary care provider coordinates a pre-operative assessment and weight loss process to include:

(1) a comprehensive psychosocial evaluation including:

- (A) evaluation for substance abuse;
- (B) evaluation for psychiatric illness which would preclude the member from participating in pre-surgical weight loss and evaluation program or successfully adjusting to the post surgical lifestyle changes;
- (C) if applicable, documentation that the member has been successfully treated for a psychiatric illness and has been stabilized for at least six months; and
- (D) if applicable, documentation that the member has been rehabilitated and is free from drug and/or alcohol for a period of at least one year.

(2) an independent medical evaluation performed by an internist experienced in bariatric medicine who is contracted with the OHCA to assess the member's operative morbidity and mortality risks.

(3) a surgical evaluation by an OHCA contracted surgeon who has credentials to perform bariatric surgery.

(4) participation in a six month weight loss program prior to surgery, under the supervision of an OHCA contracted medical provider. The member must, within 180 days from the initial or member candidacy prior authorization approval, lose at least five percent of member's initial body weight.

(b) When all requirements have been met, a prior authorization for surgery must be obtained from OHCA. This authorization can not be requested before the initial 180 day weight loss program has been completed.

(1) If the member does not meet the weight loss requirement in the allotted time the member will not be approved for bariatric surgery.

(2) The member's provider must restart the prior authorization process if this requirement is not met.

(c) The bariatric surgery facility or surgeon must, on an annual basis, provide to the OHCA the members statistical data which includes but is not limited to, mortality, hospital readmissions, re-operation, morbidity and average weight loss data.

(d) OHCA considers surgery to correct complications from bariatric surgery, such as obstruction or stricture, medically necessary.

(e) OHCA considers repeat bariatric surgery medically necessary for a member whose initial bariatric surgery was medically necessary, and member meets either of the following criteria:

(1) has not lost more than fifty percent of excess body weight two years following the primary bariatric surgery procedure and is in compliance with prescribed nutrition and exercise programs following the procedure; or

(2) failure due to dilation of the gastric pouch if the initial procedure was successful in inducing weight loss prior to the pouch dilation and the member is in compliance with prescribed nutrition and exercise programs following the initial procedure.

(f) OHCA may withdraw authorization of payment for the bariatric surgery at any time if the OHCA determines that the member or provider is not in compliance with any of the requirements.

317:30-5-138. General coverage [REVOKED]

(a) After determining member requirements are met (see OAC 317:30-5-139) and receiving prior authorization from OHCA, the primary care provider coordinates a process to include:

(1) a comprehensive psychosocial evaluation including:

- (A) evaluation for substance abuse;
- (B) evaluation for psychiatric illness which would preclude the member from participating in pre surgical dietary requirements or post surgical lifestyle changes;
- (C) if applicable, documentation that the member has been successfully treated for a psychiatric illness and has been stabilized for at least six months; and
- (D) if applicable, documentation that the member has been rehabilitated and is free from drug and/or alcohol for a period of at least one year.

(2) an independent medical evaluation performed by an internist who is contracted with the OHCA to assess the member's preoperative and mortality risks.

(3) a surgical evaluation by an OHCA contracted surgeon who has credentials to perform bariatric surgery.

(4) participation in a weight loss program prior to surgery, under the supervision of an OHCA contracted medical provider. The member must, within one hundred and eighty days from the approval of the OHCA's prior authorization, lose at least five percent of member's initial body weight.

(A) If the member does not meet the weight loss requirement in the allotted time the prior authorization is cancelled.

(B) The member's provider must reapply for prior authorization to restart the process if the requirement is not met.

(b) When all requirements have been met, a prior authorization for surgery must be obtained from OHCA. This authorization can not be requested before the initial 180 day weight loss program has been completed.

(c) The bariatric surgery facility or surgeon must, on an annual basis, provide to the OHCA the members statistical data which includes but is not limited to, mortality, hospital readmissions, re-operation, morbidity data and average weight loss.

(d) OHCA considers surgery to correct complications from bariatric surgery medically necessary, such as obstruction or stricture.

(e) OHCA considers repeat bariatric surgery medically necessary for a member whose initial bariatric surgery was medically necessary, and member meets either of the following criteria:

(1) has not lost more than fifty percent of excess body weight two years following the primary bariatric surgery

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procedure and is in compliance with prescribed nutrition and exercise programs following the procedure; or

(2) ~~revision of a primary bariatric surgery procedure that failed due to dilation of the gastric pouch if the procedure was successful in inducing weight loss prior to the pouch dilation, and is in compliance with prescribed nutrition and exercise programs following the procedure.~~

(f) ~~OHCA may withdraw authorization of payment for the bariatric surgery at any time if the OHCA determines that the member or provider is not in compliance with any of the requirements.~~

317:30-5-139. Member requirements [REVOKED]

Members must meet the following criteria to be eligible:

- (1) ~~be between 18 and 65 years of age;~~
- (2) ~~have body mass index (BMI) of thirty five or greater;~~
- (3) ~~be diagnosed with one of the following:~~
 - (A) ~~diabetes mellitus;~~
 - (B) ~~degenerative joint disease of a major weight bearing joint(s). The member must be a candidate for joint replacement surgery if weight loss is achieved;~~
 - (C) ~~a rare co-morbid condition in which there is medical evidence that bariatric surgery is medically necessary and that the benefits of bariatric surgery outweigh the risk of surgical mortality.~~
- (4) ~~have presence of obesity that has persisted for at least 5 years;~~
- (5) ~~have attempted weight loss in the past without successful long-term weight reduction, which must be documented by a physician;~~
- (6) ~~have absence of other medical conditions that would increase the member's risk of surgical mortality or morbidity; and~~
- (7) ~~the member is not pregnant or planning to become pregnant in the next two years.~~

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

[OAR Docket #10-576]

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Subchapter 5. Individual Providers and Specialties
Part 17. Medical Suppliers
317:30-5-210.1. [NEW]
317:30-5-210.2. [NEW]
317:30-5-211.1. [AMENDED]
317:30-5-211.8. [REVOKED]
317:30-5-211.13. [AMENDED]
317:30-5-211.14. [AMENDED]
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Durable medical equipment (DME) rules are revised to provide further clarification in regards to the services available to adults and the additional services available to children. These revisions will further align policy with reimbursement practices and help alleviate confusion to the provider community. Revisions include specifying general coverage for adults, providing definition and clarification in regard to adult coverage of prosthetic and orthotic devices, specifying general coverage for children, and general policy cleanup as it relates to these sections.

CONTACT PERSON:

Tywanda Cox at 522-7153

**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 MAY 13, 2010:**

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 17. MEDICAL SUPPLIERS

317:30-5-210.1. Coverage for adults

Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for adults is specified in OAC 317:30-5-211.1 through OAC 317:30-5-211.18.

317:30-5-210.2. Coverage for children

(a) Coverage. Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for children includes the specified coverage for adults found in OAC 317:30-5-211.1 through OAC 317:30-5-211.18. In addition the following are covered items for children only:

- (1) Orthotics and prosthetics.
- (2) Enteral nutrition is considered medically necessary for certain conditions in which, without the products, the member's condition would deteriorate to the point of severe malnutrition.

(A) Enteral nutrition must be prior authorized. PA requests must include:

- (i) the member's diagnosis;
- (ii) the impairment that prevents adequate nutrition by conventional means;
- (iii) the member's weight history before initiating enteral nutrition that demonstrates oral intake without enteral nutrition is inadequate;
- (iv) the percentage of the member's average daily nutrition taken by mouth and by tube; and
- (v) prescribed daily caloric intake.

(B) Enteral nutrition products that are administered orally and related supplies are not covered.

(b) EPSDT. Services deemed medically necessary and allowable under federal regulations may be covered by the EPSDT Child Health program even though those services may not be part of the SoonerCare program. These services must be prior authorized.

(c) Medical necessity. Federal regulations require OHCA to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or that are considered experimental.

317:30-5-211.1. Definitions

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

"Adaptive equipment" means devices, aids, controls, appliances or supplies of either a communication or adaptive type, determined necessary to enable the person to increase his or her ability to function in a home and community based setting or private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) with independence and safety.

"Capped rental" means monthly payments for the use of the Durable Medical Equipment (DME) for a limited period of time not to exceed 13 months. Items are considered purchased after 13 months of continuous rental.

"Certificate of medical necessity (CMN)" means a certificate required to help document the medical necessity and other coverage criteria for selected items, those items are

defined in this Chapter. The physician's certification must include the member's diagnosis, the reason the equipment is required, and the physician's estimate, in months, of the duration of its need.

"Customized DME" means items of DME which have been uniquely constructed or substantially modified for a specific member according to the description and orders of the member's treating physician. For instance, a wheelchair would be considered "customized" if it has been:

- (A) measured, fitted or adapted in consideration of the member's body size, disability, period of need, or intended use;
- (B) assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs; and
- (C) intended for an individual member's use in accordance with instructions from the member's physician.

"DME information form (DIF)" means a document used to provide additional information needed to process a claim. ~~The DIF is completed by the supplier and is not reviewed and signed by the physician. In the event of a post payment audit, the supplier must be able to produce the DIF and, if requested, produce information to substantiate the information on the DIF.~~

"Durable medical equipment (DME)" means equipment that can withstand repeated use, i.e.; the type of item that could normally be rented is used to serve a medical purpose, is not useful to a person in the absence of an illness or injury, and is used in the most appropriate setting including the home or workplace.

"Invoice" means a document that provides the following information when applicable; description of product, quantity, quantity in box, purchase price (less any discounts, rebates or commissions received), NDC, strength, dosage, provider, seller's name and address, purchaser's name and address and date of purchase. At times, visit notes will be required to determine how much of the supply was expended. When possible, the provider should identify the SoonerCare member receiving the equipment or supply on the invoice.

"Medical supplies" means an article used in the cure, mitigation, treatment, prevention, or diagnosis of illnesses. Disposable medical supplies are medical supplies consumed in a single usage and do not include skin care creams or cleansers. Medical supplies do not include surgical supplies or medical or surgical equipment.

"OHCA CMN" means a certificate required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this chapter. The physician's certification must include the member's diagnosis, the reason equipment is required, and the physician's estimate, in months, of the duration of its need. This certificate is used when the OHCA requires a CMN and one has not been established by CMS.

"Orthotics" means an item used for the correction or prevention of skeletal deformities.

"Prosthetic devices" means a replacement, corrective, or supportive device (including repair and replacement parts for same) worn on or in the body, to artificially replace a missing

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portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.

317:30-5-211.8. Coverage [REVOKED]

~~Durable medical equipment, adaptive equipment, medical supplies and prosthetic devices prescribed by the appropriate medical provider and medically necessary are covered for adults and children as set forth in coverage guidelines.~~

317:30-5-211.13. ~~Prosthetic devices~~ **Prosthetics and orthotics**

Coverage of prosthetics for adults is limited to (1) home dialysis equipment and supplies, (2) nerve stimulators, (3) external breast prosthesis and support accessories, and (4) implantable devices inserted during the course of a surgical procedure. ~~Prosthetic devices~~ Prosthetics prescribed by an appropriate medical provider as ~~conditioned and as specified in this section are covered items for adults. There is no coverage of orthotics for adults.~~

~~(1) **Certificate of medical necessity.** The medical supplier must have a fully completed CMN on file for prosthetic items including Transcutaneous Electric Nerve Stimulators (TENS).~~

~~(2) **Prior authorization.** Prosthetic devices, except for cataract lenses, require prior authorization.~~

~~(3) **Home dialysis.** Equipment and supplies are covered items for members receiving home dialysis treatments only.~~

~~(4) **Nerve stimulators.** Payment is made for rental equipment which must not exceed the purchase price, for transcutaneous nerve stimulators, implanted peripheral nerve stimulators, and neuromuscular stimulators. After continuous rental for 13 months, the equipment becomes the property of the OHCA to be used by the member until no longer medically necessary.~~

~~(5) **Breast prosthesis, bras, and prosthetic garments.**~~

(A) Payment is limited to:

- (i) one prosthetic garment with mastectomy form every 12 months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;
- (ii) two mastectomy bras per year; and
- (iii) one silicone or equal breast prosthetic per side every 24 months; or
- (iv) one foam prosthetic per side every six months.

(B) Payment will not be made for both a silicone and a foam prosthetic in the same 12 month period.

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

(D) A breast prosthesis can be replaced if:

- (i) lost;

(ii) irreparably damaged (other than ordinary wear and tear); or

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

(E) External breast prostheses are not covered after breast reconstruction is performed except in instances where a woman with breast cancer receives reconstructive surgery following a mastectomy, but the breast implant fails or ruptures and circumstances are such that an implant replacement is not recommended by the surgeon and/or desired by the member.

~~(6) **Prosthetic devices inserted during surgery.** Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.~~

317:30-5-211.14. Nutritional support

(a) **Parenteral nutrition.** The member must require intravenous feedings to maintain weight and strength commensurate with the member's overall health status. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements.

(1) The member must have a permanent impairment. Permanence does not require a determination that there is no possibility that the member's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least three months), the test of permanence is met. Parenteral nutrition will be denied as a non-covered service in situations involving temporary impairments.

(2) The member must have a condition involving the small intestine, exocrine glands, or other conditions that significantly impair the absorption of nutrients. Coverage is also provided for a disease of the stomach and/or intestine that is a motility disorder and impairs the ability of nutrients to be transported through the GI system, and other conditions as deemed medically necessary. There must be objective medical evidence supporting the clinical diagnosis.

(3) Re-certification of parenteral nutrition will be required as medically necessary and determined by the OHCA medical staff.

(b) **Prior authorization.** A written signed and dated order must be received by the supplier before a claim is submitted to the OHCA. If the supplier bills an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary. The ordering physician is expected to see the member within 30 days prior to the initial certification or required re-certification. If the physician does not see the member within this time frame, the physician must document the reason why and describe what other monitoring methods were used to evaluate the member's parenteral nutrition needs.

(1) The ordering physician is expected to see the member within 30 days prior to the initial certification or required re-certification. If the physician does not see the member within this time frame, the physician must document the reason why and describe what other monitoring methods were used to evaluate the member's parenteral nutrition needs.

(2) A completed DIF must be kept on file by the supplier and made available to the OHCA on request. The initial request for prior authorization must include a copy of the DIF.

(c) **Enteral formulas.** Enteral formulas are covered for children only. See OAC ~~317:30-5-212~~ 317:30-5-210.2.

317:30-5-212. Coverage for children [REVOKED]

~~(a) **Coverage.** Coverage of Durable Medical Equipment, Adaptive Equipment, Medical Supplies and Prosthetic Devices for children is the same as for adults. In addition the following are covered items:~~

~~(1) All orthotic equipment (procedures) listed by Health Care Finance Administration Common Procedural Code System (HCPCS).~~

~~(2) Durable medical equipment, adaptive equipment, medical supplies and prosthetic devices determined to be medically necessary.~~

~~(3) Enteral nutrition is considered medically necessary for certain conditions in which, without the products, the member's condition would deteriorate to the point of severe malnutrition.~~

~~(A) Enteral nutrition must be prior authorized. PA requests must include:~~

- ~~(i) the member's diagnosis;~~
- ~~(ii) the impairment that prevents adequate nutrition by conventional means;~~
- ~~(iii) the member's weight history before initiating enteral nutrition that demonstrates oral intake without enteral nutrition is inadequate; and~~
- ~~(iv) the percentage of the member's average daily nutrition taken by mouth and by tube; and~~
- ~~(v) prescribed daily caloric intake.~~

~~(B) Enteral nutrition products that are administered orally and related supplies are not covered.~~

~~(b) **Prior authorization requirement.** Prior authorization is the same as adults and required for all L series HCPCS codes L5000 and above.~~

~~(c) **EPSDT.** Services deemed medically necessary and allowable under federal regulations may be covered by the EPSDT Child Health program even though those services may not be part of the SoonerCare program. These services must be prior authorized.~~

~~(d) **Medical necessity.** Federal regulations require OHCA to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or that are considered experimental.~~

317:30-5-216. Prior authorization requests

(a) **Prior authorization requirements.** Requirements vary for different types of services. Providers should refer to the service-specific sections of policy or the OHCA website for services requiring PA.

(1) **Required forms.** Form HCA-12A may be obtained at local county OKDHS offices and is available on the OHCA web site at www.okhca.org.

(2) **Certificate of medical necessity.** The prescribing provider must complete the medical necessity section of the CMN. This section cannot be completed by the supplier. The medical necessity section can be completed by any health care clinician; however, only the member's treating provider may sign the CMN. By signing the CMN, the physician is validating the completeness and accuracy of the medical necessity section. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the answers given in the medical necessity section of the CMN. These records may be requested by OHCA or its representatives to confirm concurrence between the medical records and the information submitted with the prior authorization request.

~~(3) **DIF.** The requesting supplier must complete and submit a DIF as indicated by Medicare standards unless OHCA policy indicates that a CMN or other documentation is required. By signing the DIF, the supplier is validating the information provided is complete and accurate. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the information given in the DIF.~~

(b) **Submitting prior authorization requests.** Contact information for submitting prior authorization requests may be found in the OHCA Provider Billing and Procedures Manual. An electronic version of this manual is located on the OHCA web site.

(c) **Prior authorization review.** Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed by OHCA staff to evaluate whether or not each service being requested meets SoonerCare's definition of "medical necessity" [see OAC 317:30-3-1 (f)] as well as other criteria.

(d) **Prior authorization decisions.** After the HCA-12A is processed, a notice will be issued advising whether or not the item is authorized. If authorization is issued, the notice will include an authorization number, the time period for which the device is being authorized and the appropriate procedure code.

(e) **Prior authorization does not guarantee reimbursement.** Provider status, member eligibility, and medical status on the date of service, as well as all other SoonerCare requirements, must be met before the claim is reimbursed.

(f) **Prior authorization of manually-priced items.** Manually-priced items must include documentation showing the supplier's estimated cost Manufacturer's Suggested Retail Price (MSRP) of the item with the request for prior authorization. The MSRP must be listed for each item in the "billed charges" box on the HCA-12A. If an item does not have an MSRP, the provider must include a copy of the current

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invoice indicating the cost to the provider and a statement from the manufacturer that there is no MSRP available. Reimbursement will be determined as per OAC 317:30-5-218.

[OAR Docket #10-576; filed 4-9-10]

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

[OAR Docket #10-572]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 17. Medical Suppliers

317:30-5-211.18. [NEW]

(Reference APA WF # 09-35)

AUTHORITY:

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

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Subchapter 5. Individual Providers and Specialties

Part 17. Medical Suppliers

317:30-5-211.18. [NEW]

Gubernatorial approval:

December 3, 2009

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27 Ok Reg 456

Docket number:

09-1519

(Reference APA WF # 09-35)

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Revisions are needed to clarify and establish a policy of ownership for all purchased durable medical equipment pursuant to Oklahoma state law. The rules will allow durable medical equipment purchased by SoonerCare to remain the property of the OHCA to be used for the benefit of the requesting member until it is no longer medically necessary.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 MAY 13, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 17. MEDICAL SUPPLIERS

317:30-5-211.18. Ownership of durable medical equipment

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) purchased by SoonerCare are the property of the Oklahoma Health Care Authority (OHCA) to be used for the benefit of the requesting member until it is no longer medically necessary. At such time as the item is no longer medically necessary, OHCA or an OHCA contractor may retrieve the DMEPOS product if it is determined to be administratively and fiscally prudent.

[OAR Docket #10-572; filed 4-9-10]

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

[OAR Docket #10-573]

RULEMAKING ACTION:

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RULES:

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-22. [AMENDED]

(Reference APA WF # 09-38)

AUTHORITY:

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Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-22. [AMENDED]

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27 Ok Reg 108

Docket number:

09-1281

(Reference APA WF # 09-38)

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rule revisions are needed to correct an inconsistency in the regular obstetrical care policy and the high risk policy with regards to limitations for ultrasounds. Rule revisions are needed to reflect that providers may use prenatal assessment forms which cover the same elements as the American College of Obstetricians and Gynecologist (ACOG) form. Currently, rules specify that the ACOG assessment form must be used. This narrow specification is impeding providers' ability to utilize electronic records and forms with the same information.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 MAY 13, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALITIES

PART 1. PHYSICIANS

317:30-5-22. Obstetrical care

(a) Obstetrical (OB) care is billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery is used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total obstetrical care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the ante partum visits. The ante partum care during the prenatal care period includes all care by the OB attending physician except major illness distinctly unrelated to the pregnancy.

(b) Procedures paid separately from total obstetrical care are listed in (1) - (8) of this subsection.

(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form or form covering same elements as ACOG and the most

recent version of the Oklahoma Health Care Authority's Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one assessment per provider and no more than two per pregnancy.

(2) Medically necessary real time ante partum diagnostic ultrasounds will be paid for in addition to ante partum care, delivery and post partum obstetrical care under defined circumstances. To be eligible for payment, ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).

(A) One abdominal or vaginal ultrasound will be covered in the first trimester of pregnancy. The ultrasound must be performed by a board certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in obstetrical ultrasonography.

(B) One ultrasound after the first trimester will be covered. This ultrasound must be performed by a board certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification in obstetrical ultrasonography.

(C) Additional ultrasounds, including detailed ultrasounds and re-evaluations of previously identified or suspected fetal or maternal anomalies must be performed by an active candidate or Board Certified diplomat in Maternal-Fetal Medicine. Up to six repeat ultrasounds are allowed after which, prior authorization is required.

(3) Standby attendance at Cesarean Section (C-Section), for the purpose of attending the baby, is compensable when billed by a physician not participating in the delivery.

(4) Spinal anesthesia administered by the attending physician is a compensable service and is billed separately from the delivery.

(5) Amniocentesis is not included in routine obstetrical care and is billed separately. Payment may be made for an evaluation and management service and amniocentesis on the same date of service. This is an exception to general information regarding surgery found at OAC 317:30-5-8.

(6) Additional payment is not made for the delivery of twins. If one twin is delivered vaginally and one is delivered by C-section by the same physician, the higher level procedure is paid. If one twin is delivered vaginally and one twin is delivered by C-Section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment is not made to the same physician for both standby and assistant at C-Section.

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- (7) One non stress test and/or biophysical profile to confirm a suspected high risk pregnancy diagnosis. The non stress test and/or biophysical profile must be performed by an active candidate or Board Certified diplomate in Maternal Fetal Medicine.
- (8) Nutritional counseling in a group setting for members with gestational diabetes. Refer to OAC 317:30-5-1076(5).
- (c) Assistant surgeons are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at C-Section bill separately for the prenatal and the six weeks postpartum office visit.
- (d) Procedures listed in (1) - (5) of this subsection are not paid or not covered separately from total obstetrical care.
- (1) Additional non stress tests, unless the pregnancy is determined medically high risk. See OAC 317:30-5-22.1.
- (2) Standby at C-Section is not compensable when billed by a physician participating in delivery.
- (3) Payment is not made for an assistant surgeon for obstetrical procedures that include prenatal or post partum care.
- (4) An additional allowance is not made for induction of labor, double set-up examinations, fetal stress tests, or pudendal anesthetic. Providers must not bill separately for these procedures.
- (5) Fetal scalp blood sampling is considered part of the total OB care.
- (e) Obstetrical coverage for children is the same as for adults with additional procedures being covered due to EPSDT provisions if determined to be medically necessary.
- (1) Services deemed medically necessary and allowable under federal Medicaid regulations are covered by the EPSDT/OHCA Child Health ~~program~~ Program even though those services may not be part of the Oklahoma Health Care Authority SoonerCare program. Such services must be prior authorized.
- (2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

[OAR Docket #10-573; filed 4-9-10]

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

[OAR Docket #10-571]

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RULES:

Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
317:30-5-42.11. [AMENDED]
(Reference APA WF # 09-34)

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Part 3. Hospitals
317:30-5-42.11. [AMENDED]

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October 2, 2009

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27 Ok Reg 110

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09-1280

(Reference APA WF # 09-34)

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rule revisions are needed to provide clarification that observation services are not covered as part of another service i.e. post operative monitoring; recovery after diagnostic testing or concurrently with therapeutic services such as chemotherapy. Without the revisions to the rule providers will not have clarification of when observation services are not covered.

CONTACT PERSON:

Tywanda Cox at 522-7153

**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 MAY 13, 2010:**

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALITIES

PART 3. HOSPITALS

317:30-5-42.11. Observation/treatment

(a) Payment is made for the use of a treatment room associated with outpatient observation services. Observation services must be ordered by a physician or other individual authorized by state law. Observation services are furnished by the hospital on the hospital's premises and include use of the bed and periodic monitoring by hospital staff. Observation

services must include a minimum of 8 hours of continuous care. Outpatient observation services are not covered when they are provided:

- (1) On the same day as an emergency department visit.
- (2) Prior to an inpatient admission, as those observation services are considered part of the inpatient DRG.
- (3) For the convenience of the member, member's family or provider.
- (4) When specific diagnoses are not present on the claim.
- (5) As part of another service, i.e. for post operative monitoring; recovery after diagnostic testing or concurrently with therapeutic services such as chemotherapy.

(b) Payment is made for observation services in a labor or delivery room. Specific pregnancy-related diagnoses are required. During active labor, a fetal non-stress test is covered in addition to the labor and delivery room charge.

[OAR Docket #10-571; filed 4-9-10]

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

[OAR Docket #10-561]

RULEMAKING ACTION:

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RULES:

Subchapter 5. Individual Providers and Specialties

Part 5. Pharmacies

317:30-5-72.1. [AMENDED]

(Reference APA WF # 09-10)

AUTHORITY:

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

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Subchapter 5. Individual Providers and Specialties

Part 5. Pharmacies

317:30-5-72.1. [AMENDED]

Gubernatorial approval:

November 3, 2009

Register publication:

27 Ok Reg 306

Docket number:

09-1363

(Reference APA WF # 09-10)

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rule revisions are needed to reflect that coverage for certain nutritional formulas and bars for children are approved with a certain diagnosis and prior authorization. The revision is needed to reflect accurate agency practices and to ensure that children are not restricted to certain nutritional formulas and bars for persons diagnosed with Phenylketonuria (PKU) only.

CONTACT PERSON:

Tywanda Cox at 522-7153

**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 MAY 13, 2010:**

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS
AND SPECIALTIES**

PART 5. PHARMACIES

317:30-5-72.1. Drug benefit

OHCA administers and maintains an Open Formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) and whose manufacturers have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), subject to the following exclusions and limitations.

(1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:

- (A) Agents used to promote fertility.
- (B) Agents primarily used to promote hair growth.
- (C) Agents used for cosmetic purposes.
- (D) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.
- (E) Agents that are experimental or whose side effects make usage controversial.
- (F) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

(2) The drug categories listed in (A) through (E) of this paragraph are covered at the option of the state and are subject to restrictions and limitations. An updated list of products in each of these drug categories is included on the OHCA's public website.

- (A) Agents used for the systematic relief of cough and colds. Antihistamines for allergies or antihistamine use associated with asthmatic conditions may

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be covered when medically necessary and prior authorized.

(B) Vitamins and Minerals. Vitamins and minerals are not covered except under the following conditions:

- (i) prenatal vitamins are covered for pregnant women up to age 50;
- (ii) fluoride preparations are covered for persons under 16 years of age or pregnant; and
- (iii) vitamin D, metabolites, and analogs when used to treat end stage renal disease are covered.

(C) Agents used for smoking cessation. A limited smoking cessation benefit is available.

(D) Coverage of non-prescription or over the counter drugs is limited to:

- (i) Insulin, PKU formula and amino acid bars, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions.
- (ii) certain smoking cessation products,
- (iii) family planning products, and
- (iv) OTC products may be covered if the particular product is both cost-effective and clinically appropriate.

(E) Coverage of food supplements is limited to Phenylketonuria (PKU) PKU formula and amino acid bars for members diagnosed with PKU, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions when medically necessary and prior authorized.

(3) All covered outpatient drugs are subject to prior authorization as provided in OAC 317-30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

- (A) the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. § 1396r-8; or
- (B) the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

[OAR Docket #10-561; filed 4-9-10]

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

[OAR Docket #10-558]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Program Waiver Services
317:30-5-761. [AMENDED]
317:30-5-763. [AMENDED]

(Reference APA WF # 09-06A)

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 440.180; 42 CFR 440.181

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Part 85. ADvantage Program Waiver Services
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317:30-5-763. [AMENDED]

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March 24, 2009

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26 Ok Reg 994

Docket number:

09-541

(Reference APA WF # 09-06A)

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Agency rules are revised to allow reimbursement for Assisted Living services for SoonerCare members who are eligible for the ADvantage Waiver program. By expanding the ADvantage program to include Assisted Living services, some SoonerCare members will be able to remain in a more homelike environment rather than having to be institutionalized in a nursing facility. ADvantage program services provided in an assisted living center will be less costly than institutional care and are anticipated to result in savings to the Oklahoma Health Care Authority in the form of reduced expenditures for nursing facility services.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 MAY 13, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-761. Eligible providers

ADvantage Program service providers, except pharmacy providers, must be certified by the ADvantage Program ~~Administrative Agent~~ ADvantage Administration (AA) and all providers must have a current signed SoonerCare contract on file with the Medicaid Agency (Oklahoma Health Care Authority).

(1) The provider programmatic certification process ~~shall verify~~ verifies that the provider meets licensure, certification and training standards as specified in the waiver document and agrees to ADvantage Program Conditions of Participation. Providers must obtain programmatic certification to be ADvantage Program certified.

(2) The provider financial certification process ~~shall verify~~ verifies that the provider uses sound business management practices and has a financially stable business. All providers, except for NF Respite, Medical Equipment and Supplies, and Environmental Modification providers, must obtain financial certification to be ADvantage Program certified.

(3) Providers may fail to gain or may lose ADvantage Program certification due to failure to meet either programmatic or financial standards.

(4) At a minimum, ~~the AA reevaluates~~ provider financial certification is reevaluated annually.

(5) ~~The AA relies upon the Oklahoma Department of Human Services (OKDHS)/Aging Services Division (ASD) for ongoing programmatic evaluation of~~ evaluates Adult Day Care and Home Delivered Meal providers for continued programmatic certification compliance with ADvantage programmatic certification requirements. For Assisted Living Services provider programmatic certification, the ADvantage program relies in part upon the Oklahoma State Department of Health/Protective Health Services for review and verification of provider compliance with ADvantage standards for Assisted Living Services providers. Providers of Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, CD-PASS, and NF Respite services do not have a programmatic evaluation after the initial certification.

(6) OKDHS/ASD may authorize a legally responsible spouse or legal guardian of an adult member to be ~~Medicaid~~ SoonerCare reimbursed under the 1915(c) ADvantage Program as a service provider, if the provider meets all of the following authorization criteria and monitoring provisions:

(A) Authorization for a spouse or legal guardian to be the care provider for a member may occur only if the member is offered a choice of providers and documentation demonstrates that:

- (i) either no other provider is available; or
- (ii) available providers are unable to provide necessary care to the member; or
- (iii) the needs of the member are so extensive that the spouse or legal guardian who provides the care is prohibited from working outside the home due to the member's need for care.

(B) The service must:

- (i) meet the definition of a service/support as outlined in the federally approved waiver document;
- (ii) be necessary to avoid institutionalization;
- (iii) be a service/support that is specified in the individual service plan;
- (iv) be provided by a person who meets the provider qualifications and training standards specified in the waiver for that service;
- (v) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the State Medicaid Agency for the payment of personal care or personal assistance services;
- (vi) not be an activity that the spouse or legal guardian would ordinarily perform or is responsible to perform. If any of the following criteria are met, assistance or care provided by the spouse or guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or guardian:

(I) spouse or guardian has resigned from full-time/part-time employment to provide care for the member; or

(II) spouse or guardian has reduced employment from full-time to part-time to provide care for the member; or

(III) spouse or guardian has taken a leave of absence without pay to provide care for the member; or

(IV) spouse or guardian provides assistance/care for the member 35 or more hours per week without pay and the member has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the member.

(C) The spouse or legal guardian who is a service provider will comply with the following:

- (i) not provide more than 40 hours of services in a seven day period;
- (ii) planned work schedules must be available in advance to the member's Case Manager, and variations to the schedule must be noted and supplied two weeks in advance to the Case Manager unless change is due to an emergency;
- (iii) maintain and submit time sheets and other required documentation for hours paid; and
- (iv) be documented in the service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse

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or legal guardian as a paid service provider. The AA will monitor through documentation submitted by the Case Manager the following:

- (i) at least quarterly reviews by the Case Manager of expenditures and the health, safety, and welfare status of the individual ~~recipient member~~;
 - and
 - (ii) face-to-face visits with the ~~recipient member~~ by the Case Manager on at least a semi annual basis.
- (7) The ~~AA~~ of OKDHS Aging Service Division (OKDHS/ASD) periodically performs a programmatic audit of Case Management, Home Care (providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services), ~~Comprehensive Home Care Assisted Living Services~~, and CD-PASS providers. If due to a programmatic audit, a provider Plan of Correction is required, the AA stops new case referrals to the provider until the Plan of Correction has been approved and implemented. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the ~~AA~~ and OKDHS/ASD, members determined to be at risk for health or safety may be transferred from a provider requiring a Plan of Correction to another provider.

317:30-5-763. Description of services

Services included in the ADvantage Program are as follows:

(1) Case Management.

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Prior

to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), Case Managers are required to receive training and demonstrate knowledge regarding CD-PASS service delivery model, "Independent Living Philosophy" and demonstrate competency in Person-centered planning.

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

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

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

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

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

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

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

(2) Respite.

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing

facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the plan of care.

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

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

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

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

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

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

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

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

(4) **Environmental Modifications.**

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

(B) All services require prior authorization.

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

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

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring ~~services~~ supplies which are shipped to the member are compensable only when the member remains eligible for waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled nursing facility or nursing home. It is the provider's responsibility to ~~check on~~ verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the ~~Medicaid~~ SoonerCare rate, or actual acquisition cost plus 30 percent. All services must be prior authorized.

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

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

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

(7) **Skilled Nursing.**

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational

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nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

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

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

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

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

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

(I) ~~filling~~ preparing a one-week supply of insulin syringes for a blind diabetic who can safely self-inject the medication but cannot fill his/her own syringe. This service would

include monitoring the member's continued ability to self-administer the insulin;

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

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

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

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

(B C) ~~Skilled~~ Nursing service ~~is~~ can be billed for service plan development and/or assessment/evaluation services or, for ~~non-assessment~~ other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. ~~Skilled~~ Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure ~~code is~~ codes are used to bill for all other authorized ~~skilled~~ nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to ~~produce~~ perform a nurse evaluation is also an agreement, ~~as well,~~ to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation ~~shall be~~ is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) Home Delivered Meals.

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as

established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) Occupational Therapy services.

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

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

(10) Physical Therapy services.

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a

physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(11) Speech and Language Therapy Services.

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

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

(12) Respiratory Therapy Services.

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for

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the member. Treatment involved use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(13) Hospice Services.

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

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

(14) ADvantage Personal Care.

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

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

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

(15) Personal Emergency Response System.

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

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

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

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

(A) Consumer-Directed Personal Assistance Services and Supports are Personal Services Assistance and Advanced Personal Services Assistance that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self care, and mobility. CD-PASS services are delivered as authorized on the service plan. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member may designate an adult family member or friend, an individual who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing these employer functions. The member:

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

(B) The service Personal Services Assistance may include:

- (i) assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both;
- (ii) assistance with routine bodily functions that may include:
 - (I) bathing and personal hygiene;
 - (II) dressing and grooming;

(III) eating including meal preparation and cleanup;

(iii) assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores;

(iv) companion type assistance that may include letter writing, reading mail and providing escort or transportation to participate in approved activities or events. "Approved activities or events" means community civic participation guaranteed to all citizens including but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member that may include shopping for food, clothing or other necessities, or for participation in other activities or events that are specifically approved on the service plan.

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

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

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(viii) apply non-sterile dressings to superficial skin breaks or abrasions; and

(ix) use Universal precautions as defined by the Center for Disease Control.

(D) The service Financial Management Services are program administrative services provided to participating CD-PASS employer/members by the ~~ADvantage Program Administrative Agent OKDHS/ASD~~. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Personal Services Assistant or Advanced Personal Services Assistant; and

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

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

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

(17) **Institution Transition Services.**

(A) Institution Transition Services are those services that are necessary to enable an individual to leave the institution and receive necessary support through ADvantage waiver services in their home and/or in the community.

(B) Institution Transition Case Management Services are services as described in OAC 317:30-5-763(1) required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home,

and without which, the individual would continue to require institutionalization. ADvantage Transition Case Management Services assist institutionalized individuals that are eligible to receive ADvantage services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transition Case Management Services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the service plan, including necessary Institution Transition Services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transition Case Management Services may be authorized to assist individuals that have not previously received ~~Advantage~~ ADvantage services but have been referred by the ~~AA~~ or OKDHS/ASD to the Case Management Provider for assistance in transitioning from the institution to the community with ~~Advantage~~ ADvantage services support.

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

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

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

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

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

(iii) Institutional Transition Services are provided to the individual within 180 days of discharge from the institution;

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

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

(18) **Assisted Living Services.**

(A) Assisted Living Services are personal care and supportive services that are furnished to waiver members who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident

needs and to provide supervision, safety and security. Services also include social and recreational programming and medication assistance (to the extent permitted under State law). The assisted living services provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center. Nursing services are incidental rather than integral to the provision of assisted living services. ADvantage reimbursement for Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities and exercise and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the participant as determined through individualized assessment and documented on the participant's service plan.

(B) The ADvantage Assisted Living Services philosophy of service delivery promotes service member choice, and to the greatest extent possible, service member control. Members have control over their living space and choice of personal amenities, furnishing and activities in their residence. The Assisted Living Service provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery that emphasizes member dignity, privacy, individuality, and independence.

(C) ADvantage Assisted Living required policies for Admission/Termination of services and definitions.

(i) ADvantage-certified Assisted Living Centers (ALCs) are required to accept all eligible ADvantage members who choose to receive services through the ALC subject only to issues relating to:

(I) unit availability;

(II) the compatibility of the participant with other residents; and

(III) the center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage participants.

(iii) Mild or moderate cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify

whether they are able to accommodate individuals who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the ADvantage Administration (AA). Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage Case Manager, the member and/or member's designated representative and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy and dignity. Inability to meet those needs will not be recognized as a reason for determining that an ADvantage participant's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed in the description of assisted living center services in the Oklahoma State Department of Health regulations (OAC 310:663-3-3) except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the following services:

(I) Provide an emergency call system for each participating ADvantage member;

(II) Provide up to three meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to members' needs and choices; and

(III) Arrange or coordinate transportation to and from medical appointments.

(vi) The provider may offer any specialized service or unit for residents with Alzheimer's disease and related dementias, physical disabilities or other special needs that the facility intends to market.

(vii) If the provider arranges and coordinates services for members, the provider is obligated to assure the provision of those services.

(viii) Under OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person". For ADvantage Assisted Living Services, assistance with "other personal needs" in this definition includes assistance with toileting, grooming and transferring and the term "assistance" is clarified to mean hands-on help in addition to supervision.

(ix) The specific Assisted Living Services assistance provided along with amount and duration of each type of assistance is based upon the individual member's assessed need for service assistance and is specified in the ALC's service plan which is incorporated as supplemental detail into the ADvantage comprehensive service plan. The ADvantage Case Manager in cooperation with the

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Assisted Living Center professional staff develops the service plan to meet member needs. As member needs change, the service plan is amended consistent with the assessed, documented need for change in services.

(x) Definition of Inappropriate ALC Placement. Placement or continued placement of an ADvantage member in an ALC is inappropriate if any one or more of the following conditions exist:

(I) The member's needs exceed the level of services the center provides. Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs;

(II) The member exhibits behavior or actions that repeatedly and substantially interferes with the rights or well being of other residents and the ALC has documented efforts to resolve behavior problems including medical interventions, behavioral interventions and increased staffing interventions. Documentation must support that ALC attempted interventions to resolve behavior problems;

(III) The member has a medical condition that is complex, unstable or unpredictable and treatment cannot be appropriately developed and implemented in the assisted living environment. Documentation must support that ALC attempted to obtain appropriate care for the member; or

(IV) The member fails to pay room and board charges and/or the OKDHS determined vendor payment obligation.

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the assisted living center must inform the member and/or the member's representative, if any, and the member's ADvantage Case Manager. The ALC must develop a discharge plan in consultation with the member, the member's support network and the ADvantage Case Manager. The ALC and Case Manager must ensure that the discharge plan includes strategies for providing increased services, when appropriate to minimize risk and meet the higher care needs of members awaiting a move out of the ALC, if reason for discharge is inability to meet member needs. If voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage Case Manager, giving the member 30 days notice of the ALC's intent to terminate the residency agreement and move the member to a more appropriate care provider. The 30 day requirement shall not apply when emergency termination of the residency agreement is mandated by

the member's immediate health needs or when termination of the residency agreement is necessary for the physical safety of the member or other residents of the ALC. The written notice of involuntary termination of residency for reasons of inappropriate placement must include:

(I) a full explanation of the reasons for the termination of residency;

(II) the date of the notice;

(III) the date notice was given to the member and the member's representative;

(IV) the date by which the member must leave the ALC; and

(V) notification of appeal rights and process for submitting appeal of termination of Medicaid Assisted Living services to the OHCA.

(D) ADvantage Assisted Living Services provider standards in addition to licensure standards.

(i) Physical environment

(I) The ALC must provide lockable doors on the entry door of each unit and a lockable compartment within each member unit for valuables. Member residents must have exclusive rights to their units with lockable doors at the entrance of their individual and/or shared unit except in the case of documented contraindication. Units may be shared only if a request to do so is initiated by the member resident.

(II) The ALC must provide each unit with a means for each member resident to control the temperature in the individual living unit through the use of a damper, register, thermostat, or other reasonable means that is under the control of the resident and that preserves resident privacy, independence and safety, provided that the Oklahoma State Department of Health may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(III) For ALCS built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space (including closets and storage area) of 250 square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space (including closets and storage area) of 360 square feet.

(IV) The ALC shall provide a private bathroom for each living unit which must be equipped with one lavatory, one toilet, and one bathtub or shower stall.

- (V) The ALC must provide at a minimum a kitchenette, defined as a space containing a refrigerator, cooking appliance (microwave is acceptable), and adequate storage space for utensils.
- (VI) The member is responsible for furnishing their rental unit. If a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can and lamp, or if the member supplied furnishings pose a health or safety risk, the member's Case Manager in coordination with the ALC must assist the member in obtaining basic furnishings for the unit.
- (VII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, the state and local sanitary codes, state building and fire safety codes and laws and regulations governing use and access by persons with disabilities.
- (VIII) The ALC must ensure the design of common areas accommodates the special needs of their resident population and that the residential unit accommodates the special needs of the individual in compliance with ADA Accessibility Guidelines (28 CFR Part 36 Appendix A).
- (IX) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.
- (X) The ALC must provide appropriately monitored outdoor space for resident use.
- (ii) Sanitation
- (I) The ALC must maintain the facility, including its individual units, that is clean, safe, sanitary, insect and rodent free, odorless, and in good repair at all times.
- (II) The ALC must maintain buildings and grounds in a good state of repair and in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, by-laws and codes.
- (III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.
- (IV) The ALC must provide housekeeping in member units that maintains a safe, clean and sanitary environment.
- (V) The ALC must have policies and procedures for members' pets.
- (iii) Health and Safety
- (I) The ALC must provide building security that protects residents from intruders with security measures appropriate to building design, environment risk factors and the resident population.
- (II) The ALC must respond immediately and appropriately to missing residents, accidents, medical emergencies or deaths.
- (III) The ALC must have a plan in place to prevent, contain and report any diseases that are considered to be infectious and/or are listed as diseases that must be reported to the Oklahoma State Department of Health.
- (IV) The ALC must adopt policies for prevention of abuse, neglect and exploitation that include screening, training, prevention, investigation, protection during investigation and reporting.
- (V) The ALC must provide services and facilities that accommodate the needs of resident to safely evacuate in the event of fires or other emergencies.
- (VI) The ALC must ensure that staff are trained to respond appropriately to emergencies.
- (VII) The ALC staff must ensure that fire safety requirements are met.
- (VIII) The ALC must offer meals that provide balanced and adequate nutrition for residents.
- (IX) The ALC must adopt safe practices for the preparation and delivery of meals;
- (X) The ALC must provide a 24-hour response to personal emergencies that is appropriate to the needs of the resident population.
- (XI) The ALC must provide safe transportation to and from ALC sponsored social/recreational outings.
- (iv) Staff to resident ratios
- (I) The ALC must ensure that a sufficient number of trained staff be on duty, awake, and present at all times, 24 hours a day, seven days a week, to meet the needs of residents and to carry out all the processes listed in the ALC's written emergency and disaster preparedness plan for fires and other natural disasters.
- (II) The ALC must ensure that staffing is sufficient to meet the needs of the ADvantage Program residents in accordance with each individual's ADvantage Service Plan.
- (III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.
- (v) Staff training and qualifications
- (I) The ALC must ensure that all staff have qualifications consistent with their job responsibilities.
- (II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by the Oklahoma Department of Health;

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- (III) The ALC must provide staff orientation and ongoing training to develop and maintain the knowledge and skills of staff. All direct care and activity staff receive at least eight hours of orientation and initial training within the first month of their employment and at least four hours annually thereafter. Staff providing direct care on a dementia unit must receive four additional hours of dementia specific training. Annual first aid and CPR certification do not count towards the four hours of annual training.
- (vi) Staff supervision
- (I) The ALC must ensure delegation of tasks to non-licensed staff must be consistent and in compliance with all applicable State regulations including, but not limited to, the Oklahoma Nurse Practice Act and the OSDH Nurse Aide Certification rules.
- (II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors the member's health and nutritional status.
- (vii) Resident rights
- (I) The ALC must provide to each member and member's representative, at the time of admission, a copy of the resident statutory rights listed in O.S. 63-1-1918 amended to include additional rights and clarification of rights as listed in the ADvantage Consumer Assurances. A copy of the resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that its staff is familiar with, and observes, the resident rights.
- (II) The ALC must conspicuously post for display in an area accessible to residents, employees and visitors, the assisted living center's complaint procedures and the name, address and telephone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each resident, the resident's representative, or where appropriate, the court appointed guardian. The ALC must ensure that all employees comply with the ALC's complaint procedure.
- (III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance/appeal rights including a description of the process for submitting a grievance/appeal of any decision that decreases Medicaid services to the member.
- (viii) Incident reporting
- (I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage Case Manager, to the ADvantage Program AA and to other entities as required by law or regulation.
- (II) Incidents requiring report by licensed Assisted Living Centers are those defined by the Oklahoma State Department of Health (OSDH) in OAC 310:663-19-1.
- (III) Reports of incidents must be made to the member's ADvantage Case Manager via facsimile or by telephone within one business day of the reportable incident's discovery. A follow-up report of the incident must be submitted via facsimile or mail to the member's ADvantage Case Manager within five business days after the incident. The final report must be filed with the member's ADvantage Case Manager and to the ADvantage Administration when the full investigation is complete not to exceed ten business days after the incident.
- (IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to either the Oklahoma Department of Human Services, the office of the district attorney in the county in which the suspected abuse, neglect, exploitation, or property misappropriation occurred or the local municipal police department or sheriff's department as soon as the person is aware of the situation, in accordance with Section 10-104.A of Title 43A of Oklahoma Statutes. Reports should also be made to the OSDH, as appropriate, in accordance with the ALC's licensure rules.
- (V) The preliminary incident report must at the minimum include who, what, when and where and the measures taken to protect the resident(s) during the investigation. The follow-up report must at the minimum include preliminary information, the extent of the injury or damage, if any, and preliminary findings of the investigation. The final report at the minimum includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions based on findings; and corrective measures to prevent future occurrences. If necessary to omit items, the final report must include why items were omitted and when they will be provided.
- (ix) Provision of or arrangement for necessary health services
- (I) The ALC must arrange or coordinate transportation for members to and from medical appointments.
- (II) The ALC must provide or coordinate with the member and the member's ADvantage Case Manager for delivery of necessary health

services. The ADvantage Case Manager is responsible for monitoring that all health-related services required by the member as identified through assessment and documented on the service plan are provided in an appropriate and timely manner.

(E) Assisted Living Services are billed per diem of service for days covered by the ADvantage member's service plan and during which the Assisted Living Services provider is responsible for providing Assisted Living serviced as needed by the member. The per diem rate for the ADvantage assisted living services for a member will be one of three per diem rate levels based upon individual member's need for service - type intensity and frequency to address member ADL/IADL and health care needs. The rate level is based upon UCAT assessment by the member's ADvantage Case Manager employed by a Case Management agency that is independent of the Assisted Living Services provider.

[OAR Docket #10-558; filed 4-9-10]

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

[OAR Docket #10-556]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Program Waiver Services
317:30-5-763.1. [AMENDED]
Part 95. Agency Personal Care Services
317:30-5-952. [AMENDED]
(Reference APA WF # 09-02A)

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 440.180; 42 CFR 440.167

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Subchapter 5. Individual Providers and Specialties
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Part 95. Agency Personal Care Services
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26 Ok Reg 756

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09-380

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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rules are revised to remove references to the Long Term Care Authority as the Administrative Agent of the ADvantage Program. The Oklahoma Department of Human Services has discontinued contracting with the Long Term Care Authority of Tulsa to perform the function as the Administrative Agent for the ADvantage Program. The Oklahoma Department of Human Services/Aging Services Division has assumed the administrative responsibility for the ADvantage Program. Rules are further revised to update definitions, terminology, and procedures.

CONTACT PERSON:

Tywanda Cox at 522-7153

**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 MAY 13, 2010:**

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS
AND SPECIALTIES**

**PART 85. ADVANTAGE PROGRAM WAIVER
SERVICES**

**317:30-5-763.1. Medicaid agency monitoring of the
ADvantage program**

The ~~Medicaid Agency~~ OHCA will monitor the eligibility process and the ADvantage plan of care approval process by reviewing annually a minimum of three percent of ADvantage member service plans and associated member eligibility documents for members selected at random from the total number of members having new, reassessed or closed plans during the most recent 12 month audit period.

(1) The ~~Medicaid Agency~~ OHCA's monitoring of the ADvantage Program is a quality assurance activity. The monitoring evaluates whether program medical and financial eligibility determinations and plans of care authorizations have been done in accordance with ~~Medicaid Agency~~ OHCA policy and requirements specified in the approved waiver document. The areas evaluated include:

- (A) Member eligibility determination;
- (B) Member "freedom of choice";
- (C) ADvantage certified and ~~Medicaid~~ SoonerCare contracted providers on the plan;
- (D) Member acceptance of the plan;

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- (E) Qualified case managers;
 - (F) Plan services are goal-oriented services; and,
 - (G) Plan of care costs are within cost cap guidelines.
- (2) At the discretion of the ~~Medicaid Agency OHCA~~, the random selection of members for audit shall be done by the MMIS or the AA Waiver Management Information System using an algorithm approved by the ~~Medicaid Agency OHCA~~.
- (3) At the discretion of the ~~Medicaid Agency OHCA~~, the ~~Medicaid Agency OHCA~~ auditor may review records at the AA place of business or have the AA mail or transport copied file documents to the ~~Medicaid Agency OHCA~~ place of business.
- (4) Missing documents and/or deficiencies found by the ~~Medicaid Agency OHCA~~ are reported to the AA for correction and/or explanation. Periodic reports of deficiencies are provided to the ~~OKDHS/ASD~~ and the AA.

PART 95. AGENCY PERSONAL CARE SERVICES

317:30-5-952. Prior authorization

Eligible members receiving personal care services must have an approved care plan developed by a PC services skilled nurse. For persons receiving ~~ADvantage~~ ADvantage Program services, the nurse works with the member's ADvantage Program Case Manager to develop the care plan. The amount and frequency of the service, to be provided to the member, is listed on the care plan. The amount and frequency of PC services is approved by the OKDHS nurse or by the ~~Administrative Agent's (AA) authorization of~~ authorized in the ADvantage Program Service Plan. At the time of a ~~PC services member's initial referral to a PC services agency, OKDHS or AA~~ OKDHS/ASD authorizes PC services, skilled nursing for PC services, needs assessment and care plan development. The number of units of PC services or PC skilled nursing the member is eligible to receive is limited to the amounts approved on the care plan as authorized by ~~OKDHS or AA~~ OKDHS/ASD. Care plans are authorized for no more than one year from the date of care plan authorization. Services provided without prior authorization are not compensable.

[OAR Docket #10-556; filed 4-9-10]

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

[OAR Docket #10-570]

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PERMANENT final adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 6. Inpatient Psychiatric Hospitals
317:30-5-95. [AMENDED]
(Reference APA WF # 09-29)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1-702 of Title 63

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Part 6. Inpatient Psychiatric Hospitals
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09-1279

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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rule revisions are needed to allow an exception for hospitals and residential psychiatric treatment centers that are operated by the state mental health department. Currently, persons between the ages of 18 to 21 are eligible to receive residential psychiatric treatment services but the residential licensing agency in the State of Oklahoma is only able to license facilities for persons up to the age of 18.

CONTACT PERSON:

Tywanda Cox at 522-7153

**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 MAY 13, 2010:**

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALITIES

PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95. General provisions and eligible providers

(a) Inpatient psychiatric hospitals or psychiatric units provide treatment in a hospital setting 24 hours a day. Psychiatric Residential Treatment Facilities (PRTF) provide non-acute inpatient facility care for members who have a behavioral

health disorder and need 24-hour supervision and specialized interventions. Payment for psychiatric and/or chemical dependency/detoxification services for adults between the ages of 21 and 64 are limited to acute inpatient hospital settings.

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

- (1) **"AOA"** means American Osteopathic Accreditation.
- (2) **"CARF"** means the Commission on Accreditation of Rehabilitation Facilities.
- (3) **"JCAHO"** means Joint Commission on Accreditation of Healthcare Organizations.
- (4) **"Licensed independent practitioner (LIP)"** means any individual permitted by law and by the licensed hospital to provide care and services, without supervision, within the scope of the individual's license and consistent with clinical privileges individually granted by the licensed hospital. Licensed independent practitioners may include Advanced Practice Nurses (APN) with prescriptive authority and Physician Assistants.
- (5) **"Psychiatric Residential Treatment Facility (PRTF)"** means a facility other than a hospital.
- (6) **"Restraint"** means any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely, or drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not the standard treatment or dosage for the patient's condition. Restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include physical escort).
- (7) **"Seclusion"** means the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving and may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

(c) **Hospitals and freestanding psychiatric facilities.** To be eligible for payment under this Section, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that is:

- (1) appropriately licensed and surveyed by the state survey agency;
- (2) accredited by JCAHO; and
- (3) contracted with the Oklahoma Health Care Authority (OHCA).

(d) **Psychiatric Residential Treatment Facility (PRTF).** A PRTF is any non-hospital facility contracted with the OHCA to provide inpatient services to SoonerCare eligible members under the age of 21. To enroll as a hospital-based or freestanding

PRTF, the provider must be appropriately state licensed pursuant to Title ~~40 O.S. § 402~~ 10 O.S. Section 402 and approved by the OHCA to provide services to individuals under age 21. Distinct PRTF units of state operated psychiatric hospitals serving individuals ages 18-22 are exempt from licensure pursuant to Title 63 O.S. Section 1-702. Out-of-state PRTFs should be appropriately licensed in the state in which they do business. In addition, the following requirements must be met:

(1) **Restraint and seclusion reporting requirements.** In accordance with Federal Regulations at 42 CFR 483.350, the OHCA requires a PRTF that provides SoonerCare inpatient psychiatric services to members under age 21 to attest, in writing, that the facility is in compliance with all of the standards governing the use of restraint and seclusion. The attestation letter must be signed by an individual who has the legal authority to obligate the facility. OAC 317:30-5-95.39 describes the documentation required by the OHCA.

(2) **Attestation letter.** The attestation letter at a minimum must include:

- (A) the name and address, telephone number of the facility, and a provider identification number;
- (B) the signature and title of the individual who has the legal authority to obligate the facility;
- (C) the date the attestation is signed;
- (D) a statement certifying that the facility currently meets all of the requirements governing the use of restraint and seclusion;
- (E) a statement acknowledging the right of the State Survey Agency (or its agents) and, if necessary, Center for Medicare and Medicaid Services (CMS) to conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences;
- (F) a statement that the facility will notify the OHCA and the State Health Department if it no longer complies with the requirements; and
- (G) a statement that the facility will submit a new attestation of compliance in the event the individual who has the legal authority to obligate the facility is no longer in such position.

(3) **Reporting of serious injuries or deaths.** Each PRTF is required to report a resident's death, serious injury, and a resident's suicide attempt to the OHCA, and unless prohibited by state law, to the state-designated Protection and Advocacy System (P and As). In addition to reporting requirements contained in this section, facilities must report the death of any resident to the CMS regional office no later than close of business the next business day after the resident's death. Staff must document in the resident's record that the death was reported to the CMS Regional Office.

(e) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.

[OAR Docket #10-570; filed 4-9-10]

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

[OAR Docket #10-575]

RULEMAKING ACTION: PERMANENT final adoption

RULES: Subchapter 5. Individual Providers and Specialties
Part 21. Outpatient Behavioral Health Services
317:30-5-241.3. [AMENDED]
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Docket number: 09-1369
(Reference APA WF # 09-39)

INCORPORATIONS BY REFERENCE: N/A

ANALYSIS: Rules are revised to provide consistency with policy and practices. Language that defines the parameters of Behavioral Health Rehabilitation Services was inadvertently omitted during the reformatting of the Outpatient Behavioral Health rules.

CONTACT PERSON: Tywanda Cox at 522-7153

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 MAY 13, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-241.3. Behavioral Health Rehabilitation (BHR) services

(a) Definition. BHRS 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.

(1) Clinical restrictions. (A) Individual. Only the BHRS and member are present for the session.

(B) Group. This service is generally performed with only the members-member(s), 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.

(2) Qualified providers. A BHRS, AODTP, or LBHP may perform BHR, following a treatment curriculum approved by a LBHP or AODTP for AOD. Staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE or trauma informed methodology.

(3) Group sizes. The minimum staffing ratio is fourteen members for each BHRS, AODTP, or LBHP for adults and eight to one for children under the age of eighteen.

(4) Limitations. (A) Transportation. Travel time to and from BHR treatment is not compensable.

(B) Time. Breaks, lunchtime and times when the member is unable or unwilling to participate are not compensable and must be deducted from the overall billed time.

(C) Location. 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, AODTP, or LBHP must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(D) Billing. 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.

(i) Group. The maximum is 24 units per day for adults and 16 units per day for children.

- (ii) **Individual.** The maximum is six units per day. Children under an ODMHSAS Systems of Care program may be prior authorized additional units as part of an intensive transition period.
- (b) **Medication training and support.**
 - (1) **Definition.** 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.
 - (2) **Limitations.**
 - (A) Medication Training and Support may not be billed for SoonerCare members who reside in ICF/MR facilities.
 - (B) One unit is allowed per month per patient without prior authorization.
 - (3) **Qualified professionals.** Must be provided by a licensed registered nurse, or a physician assistant as a direct service under the supervision of a physician.

[OAR Docket #10-575; filed 4-9-10]

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

[OAR Docket #10-577]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 5. Eligibility and Countable Income

Part 5. Countable Income and Resources

317:35-5-41.2. [AMENDED]

(Reference APA WF # 09-43)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Senate Bill 987 of the 1st Session of the 52nd Oklahoma Legislature (2009)

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Subchapter 5. Countable Income and Resources

317:35-5-41.2. [AMENDED]

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27 Ok Reg 112

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09-1282

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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

SoonerCare eligibility rules are revised to comply with Senate Bill 987 of the 1st Session of the 52nd Oklahoma Legislature (2009) by increasing certain burial trust account thresholds from \$7,500 to \$10,000 effective November 1, 2009. Oklahoma law provides that a purchases of a prepaid funeral contract may elect to make the contract irrevocable. Current rules stipulate that the face value amount in an irrevocable contract cannot exceed \$7,500 plus accrued interest. When the amount is in excess of \$7,500, the individual is ineligible for SoonerCare. Senate Bill 987 increases the irrevocable burial contract limit from \$7,500 to \$10,000 effective November 1, 2009. Therefore, rule revisions are needed to increase the threshold to \$10,000.

CONTACT PERSON:

Tywanda Cox at 522-7153

**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 MAY 13, 2010:**

**SUBCHAPTER 5. ELIGIBILITY AND
COUNTABLE INCOME**

**PART 5. COUNTABLE INCOME AND
RESOURCES**

317:35-5-41.2. Miscellaneous Personal property

(a) Property used to produce goods and services.

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

(b) Cash savings and bank accounts.

Money on hand or in a savings account is considered as a countable resource. The member's statement that he/she does not have any money on hand or on deposit is sufficient unless there are indications to the contrary. When there is information to the contrary or

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when the member does not have records to verify the amount on deposit, verification is obtained from bank records. Title 56, O.S., Section 1671 provides that financial records obtained for the purpose of establishing eligibility for assistance or services must be furnished without cost to the member or the Agency.

(1) Checking accounts may or may not represent savings. Current bank statements are evaluated with the member to establish what, if any, portion of the account represents savings. Any income which has been deposited during the current month is not considered unless it exceeds what is considered as ordinary maintenance expense for the month.

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

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

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

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

(3) The net cash surrender value of insurance (i.e., cash surrender value less any loans or unpaid interest thereon) usually can be verified by inspection of the insurance policies and documents in the member's possession or by use of the OKDHS Form 08MP061E, Request to Insurance Company.

(4) Dividends which accrue and which remain with the insurance company increase the amount of resource. Dividends which are paid to the member are considered as income.

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

value of the insurance policy is still available to the individual. The individual is in effect, receiving the death benefits and not the cash surrender value.

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

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

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

(2) The face value of a life insurance policy, when properly assigned by the owner to a funeral home or burial association, may be used for purchasing "burial funds" as described in (1) of this subsection.

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

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

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

(f) **Irrevocable burial contract.** Oklahoma law provides that a purchaser (buyer) of a prepaid funeral contract may elect to make the contract irrevocable. The irrevocability cannot become effective until 30 days after purchase. For an irrevocable contract to be valid, the election to make it irrevocable must be made by the purchaser (owner) or the purchaser's guardian or an individual with power of attorney for the purchaser (owner). In instances where the OKDHS Form 08MA084E, Management of Recipient's Funds, is on file in the nursing facility, the form serves as a power of attorney for the administrator to purchase and/or elect to make irrevocable the burial funds for the member.

(1) If the irrevocable election was made prior to July 1, 1986, and the member received assistance on July 1,

1986, the full amount of the irrevocable contract is not considered a countable resource. This exclusion applies only if the member does not add to the amount of the contract. Interest accrued on the contract is not considered as added by the member. Any break in assistance will require that the contract be evaluated at the time of reapplication according to rules in (2) of this subsection.

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

(A) the face value amount ~~is~~ of an irrevocable burial contract cannot exceed ~~\$7,500~~ \$6,000 plus accrued interest through August 4, 1998.

(B) the face value amount of an irrevocable burial contract cannot exceed \$7,500 plus accrued interest for the period August 5, 1998, through October 31, 2009.

~~(B C) a member may exclude after November 1, 2009, state statute excludes the face value of an irrevocable burial contract, up to \$7,500 \$10,000. This exclusion includes, plus accrued interest in any combination of irrevocable contract, revocable pre-paid account, designated account or cash value in life insurance policies not used to fund the burial policy, regardless of the face value, provided the cash value in policies and designated accounts does not exceed \$1500. When the amount exceeds \$7,500 \$10,000, the member is ineligible for assistance. Accrued interest is not counted as a part of the \$7,500 \$10,000 limit regardless of when it is accrued.~~

~~(C D) the face value of life insurance policies used to fund burial contracts is counted towards the \$7,500 \$10,000 limit.~~

~~(3) For an irrevocable contract to be valid, the election to make it irrevocable must be made by the purchaser (owner) or the purchaser's guardian or an individual with power of attorney for the purchaser (owner).~~

~~(4) In instances where the OKDHS Form 08MA084E, Management of Recipient's Funds, is on file in the nursing facility, the form serves as a power of attorney for the administrator to purchase and/or elect to make irrevocable the burial funds for the member.~~

(g) **Medical insurance.** If a member is covered by insurance other than SoonerCare, then SoonerCare is the payer of last resort and should not be bill until all other payers have paid. If payment is made directly to the member, the member must reimburse OHCA up to the amount paid by SoonerCare. Any amount remaining after payment to OHCA is considered as an available resource.

[OAR Docket #10-577; filed 4-9-10]

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

[OAR Docket #10-562]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
317:35-5-41.9. [AMENDED]
(Reference APA WF # 09-15A)

AUTHORITY:

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

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Subchapter 5. Eligibility and Countable Income
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26 Ok Reg 1768

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09-907

(Reference APA WF # 09-15A)

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rules are revised to disregard as income and resources certain amounts of unemployment compensation for the purpose of determining eligibility for SoonerCare benefits, as authorized and required by the American Recovery and Reinvestment Act of 2009.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 MAY 13, 2010:

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.9. Resource disregards

In determining need, the following are not considered as resources:

- (1) The coupon allotment under the Food Stamp Act of 1977;
- (2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
- (3) Education grants (excluding Work Study) scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;
- (4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:
 - (A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS Loan Verification form, is completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Loan Verification form are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified;
 - (B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide;
 - (C) Proceeds of a loan secured by an exempt asset are not an asset;
- (5) Indian payments or items purchased from Indian payments (including judgement funds or funds held in trust) distributed per capita by the Secretary of the Interior (BIA) or distributed per capita by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgement funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., as long as the payments are paid per capita. For purposes of this Subchapter, per capita is defined as each tribal member receiving an equal amount. However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;
- (6) Special allowance for school expenses made available upon petitions (in writing) from funds held in trust for the student;

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

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

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

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

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

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

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

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

(15) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments and disaster assistance organizations;

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

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

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

- (19) A migratory farm worker's out-of-state homestead is disregarded if the farm worker's intent is to return to the homestead after the temporary absence;
- (20) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in internment camps during World War II;
- (21) Dedicated bank accounts established by representative payees to receive and maintain retroactive SSI benefits for disabled/blind children up to the legal age of 18. The dedicated bank account must be in a financial institution, the sole purpose of which is to receive and maintain SSI underpayments which are required or allowed to be deposited into such an account. The account must be set up and verification provided to SSA before the underpayment can be released;
- (22) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. Payments are not considered as income or resources. A penalty cannot be assessed against the individual if he/she disposes of part or all of the payment. The rules at OAC 317:35-5-41.6 regarding the availability of a trust do not apply if an individual establishes a trust using the settlement payment;
- (23) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);
- (24) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);
- (25) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);
- (26) For individuals with an Oklahoma Long-Term Care Partnership Program approved policy, resources equal to the amount of benefits paid on the insured's behalf by the long-term care insurer are disregarded at the time of application for long-term care services provided by SoonerCare. The Oklahoma Insurance Department approves policies as Long-term Care Partnership Program policies; ~~and~~
- (27) Worker's Compensation Medicare Set Aside Arrangements (WCMSAs), which allocate a portion of the workers' compensation settlement for future medical expenses; ~~;~~ and
- (28) Additional payments of regular unemployment compensation in the amount of \$25 per week ending June 30, 2010 and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009.

[OAR Docket #10-562; filed 4-9-10]

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

[OAR Docket #10-565]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 13. ~~Client~~Member Rights and Responsibilities
317:35-13-4. [AMENDED]
(Reference APA WF # 09-19B)

AUTHORITY:

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

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Subchapter 13. ~~Client~~Member Rights and Responsibilities
317:35-13-4. [AMENDED]

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November 3, 2009

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09-1365

(Reference APA WF # 09-19B)

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rule revisions are needed to clarify member responsibilities regarding the reporting of third party liability, utilization of private insurance and notification to medical providers of SoonerCare coverage. Implementation of this rule will reduce the amount of federal and state dollars utilized for healthcare, reducing the burden of providing costly healthcare from strained State Agency budgets and shifting it to third party resources.

CONTACT PERSON:

Tywanda Cox at 522-7153

**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 MAY 13, 2010:**

Permanent Final Adoptions

SUBCHAPTER 13. CLIENT MEMBER RIGHTS AND RESPONSIBILITIES

317:35-13-4. Release of medical information

~~Medical information paid for by the Agency is not to be released, even at the request of the individual to whom it pertains, except to another agency to which the individual has applied for services having the objective of protecting or advancing his/her welfare. However, there is nothing in Oklahoma law or federal law to prevent a physician from releasing medical information to the patient or an authorized representative of the patient. When a SoonerCare member or an authorized representative of a member, applies for services, explicit consent is given for the OHCA to release information to applicable state or federal agencies, medical providers, or an OHCA designee when the information is needed to provide, monitor or approve medical services or obtain payment of those services. Additionally, a physician may release medical information to the member or an authorized representative of the member upon written request. The physician, in such instance, would be governed by the physician-patient relationship.~~

(1) ~~Medical information that a local office has obtained from Veterans Administration or from the Bureau of Disability Insurance (Social Security Administration) cannot be released to anyone outside the Agency.~~

(2) ~~When a request is received in a local office for medical information not covered in the two preceding paragraphs, the local office refers the request immediately to the State Office, attention administrator of the division to which the request was made, where a decision will be made as to the appropriate action to be taken. The division administrator requests consultation from the Legal Division, if needed, in making this decision. The division supervisor notifies the local office of the decision.~~

(3) ~~The only exception to referral to the DHS State Office is that the Physician's Report form may be released to another physician, medical facility or other medical provider when the medical information in the report is needed for the continuity of medical care of a client. The Form contains a statement giving the physician's consent and authorizing the Agency to furnish the report to other medical providers under this situation.~~

[OAR Docket #10-565; filed 4-9-10]

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

[OAR Docket #10-581]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 15. Personal Care Services
317:35-15-8.1. [AMENDED]
(Reference APA WF # 09-50)

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 440.180; 42 CFR 440.167

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Subchapter 15. Personal Care Services
317:35-15-8.1. [AMENDED]

Gubernatorial approval:

November 3, 2009

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27 Ok Reg 308

Docket number:

09-1371

(Reference APA WF # 09-50)

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rules are revised to remove references to the Long Term Care Authority as the Administrative Agent of the ADvantage Program. The Oklahoma Department of Human Services has discontinued contracting with the Long Term Care Authority of Tulsa to perform the function as the Administrative Agent for the ADvantage Program. The Oklahoma Department of Human Services/Aging Services Division has assumed the administrative responsibility for the ADvantage Program. Rules are further revised to update definitions, terminology, and procedures.

The Oklahoma Department of Human Services/Aging Services Division has requested an amendment to rules that would revise who could be paid to serve as a Personal Care Assistant (PCA) to SoonerCare members approved for State Plan Personal Care services. Current policy allows the OKDHS Director under certain circumstances to approve payment from OKDHS state funds for Personal Care to a legally responsible family member. Those situations include instances when no other PCA is available, available PCAs are unable to provide care to the member, or the needs of the member are so extensive that the legally responsible family member who provides the care is prohibited from working outside the home due to the member's need for care. OKDHS has requested the discontinuance of this exception as a cost saving measure since OKDHS is responsible for paying the entire cost of the PCAs' services for these individuals. Currently, there are ten individuals who will be affected by this revision to policy; these individuals will remain eligible for Personal Care services and efforts are being made to find other non-related PCAs for these individuals.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 MAY 13, 2010:

SUBCHAPTER 15. PERSONAL CARE SERVICES

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

The ADvantage Administration (AA) certifies qualified Personal Care service agencies and facilitates the execution of the agencies' SoonerCare contracts on behalf of OHCA. OHCA will check the list of providers that have been barred from Medicare/SoonerCare participation to ensure that the Personal Care services agency is not listed.

(1) **Payment for Personal Care.** Payment for Personal Care services is generally made for care in the member's "own home". In addition to an owned or rented home, a rented apartment, room or shelter shared with others is considered to be the member's "own home". A facility that meets the definition of a nursing facility, room and board, licensed residential care facility, licensed assisted living facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-890.1 et seq., and Section 1-1902 et seq., and/or in any other type of settings prohibited under applicable federal or state statutes, rules, regulations, or other written instruments that have the effect of law is not a setting that qualifies as the member's "own home" for delivery of Personal Care services through SoonerCare. With prior approval of the OKDHS area nurse, Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified on the care plan.

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

(B) **Reimbursement.** Personal Care services payment on behalf of a member is made according to the type of service and number of units of Personal Care services authorized in the Service Authorization Model (SAM) packet.

(i) The amount paid to Personal Care services providers for each unit of service is according to the established SoonerCare rates for the Personal Care services. Only authorized units contained in each eligible member's individual Service Authorization Model (SAM) packet are eligible for reimbursement. Providers serving more than one Personal Care service member residing in the same residence will assure that the members' Service Authorization Model (SAM) packets combine units in the most efficient manner possible to meet the needs of all eligible persons in the residence.

(ii) Payment for Personal Care services is for tasks performed in accordance with OAC 317:30-5-951 only when listed on an authorized plan of care. Payment for Personal Care skilled nursing service is made on behalf of the member for assessment/evaluation and associated service planning per assessment/service planning visit by

the Personal Care Assessment/Service Planning Nurse.

(2) **Issue resolution.**

(A) If the member is dissatisfied with the Personal Care services provider agency or the assigned PCA, and has exhausted attempts to work with the Personal Care services agency's grievance process without resolution, the member may contact the OKDHS nurse to attempt to resolve the issues. The member has the right to appeal to the OHCA in accordance with OAC 317:2-1-2. For members receiving ADvantage services, the member or family should contact their case manager for the problem resolution. If the problem remains unresolved, the member or family should contact the Consumer Inquiry System (CIS). Providers are required to provide the CIS contact number to every member. The ADvantage Program member also has the right to appeal to the OHCA in accordance with OAC 317:2.

(B) When a problem with performance of the Personal Care attendant is identified, agency staff will conduct a counseling conference with the member and/or the attendant as appropriate. Agency staff will counsel the attendant regarding problems with his/her performance.

(3) **Persons ineligible to serve as Personal Care Assistants.** Payment from SoonerCare funds for Personal Care services may not be made to an individual who is a legally responsible family member (spouse, legal guardian or parent of a minor child) of the member to whom he/she is providing personal care services.

[OAR Docket #10-581; filed 4-9-10]

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

[OAR Docket #10-559]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 17. ADvantage Waiver Services

317:35-17-1. [AMENDED]

317:35-17-11. [AMENDED]

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May 13, 2010

SUPERSEDED EMERGENCY ACTIONS:**Superseded rules:**

Subchapter 17. ADvantage Waiver Services

317:35-17-1. [AMENDED]

317:35-17-11. [AMENDED]

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N/A

ANALYSIS:

Agency rules are revised to allow reimbursement for Assisted Living services for SoonerCare members who are eligible for the ADvantage Waiver program. By expanding the ADvantage program to include Assisted Living services, some SoonerCare members will be able to remain in a more homelike environment rather than having to be institutionalized in a nursing facility. ADvantage program services provided in an assisted living center will be less costly than institutional care and are anticipated to result in savings to the Oklahoma Health Care Authority in the form of reduced expenditures for nursing facility services.

CONTACT PERSON:

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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 MAY 13, 2010:

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-1. Overview of long-term medical care services; relationship to QMBP, SLMB, and other Medicaid services eligibility

(a) Long-term medical care for the categorically needy includes:

- (1) care in a nursing facility (refer to OAC 317:35-19);
- (2) care in a public or private intermediate care facility for the mentally retarded (refer to OAC 317:35-9);
- (3) care of persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9);
- (4) Home and Community Based Services Waivers for the Mentally Retarded (refer to OAC 317:35-9);
- (5) Personal Care services (refer to OAC 317:35-15); and
- (6) the Home and Community Based Services Waiver for frail elderly, a targeted group of adults with physical

disabilities age 21 and over who do not have mental retardation or a cognitive impairment (ADvantage Waiver).

(b) Any time an individual is certified as eligible for Medicaid SoonerCare coverage of long-term care, the individual is also eligible for other Medicaid SoonerCare services. ~~Another application or spenddown computation is not required.~~ ADvantage Waiver recipients members do not have a copayment for ADvantage services except for prescription drugs. For members residing in an ADvantage Assisted Living Center, any income beyond 150% of the federal benefit rate is available to defray the cost of the Assisted Living services received. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor pay obligation is met. Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate eligibility determination must be made for Qualified Medicare Beneficiary Plus (QMBP) or Specified Low-Income Medicare Beneficiary (SLMB) benefits. ~~Another application for QMBP or SLMB benefits is not required.~~ An ADvantage program member may reside in a licensed assisted living facility only if the assisted living center is a certified ADvantage Assisted Living Services provider from whom the member is receiving ADvantage Assisted Living services.

317:35-17-11. Determining financial eligibility for ADvantage program services

Financial eligibility for individuals in ADvantage program services is determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility.** To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS ~~Appendix C-1 form 08AX001E~~, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for ADvantage services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS ~~Appendix C-1 form 08AX001E~~, Schedule VIII. D.

(C) **Vendor payment.** For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, there is not a spenddown calculation as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor payment obligation is met.

(D) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(2) **Individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital.** For an individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of ADvantage program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in the ADvantage or HCBW/MR program, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of ADvantage services. The rules in (i) - (v) of this subparagraph apply in this situation:

- (i) If payment of income is made solely to one or the other, the income is considered available only to that individual.
- (ii) If payment of income is made to both, one-half is considered for each individual.
- (iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.
- (iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS ~~Appendix C-1 form 08AX001E~~, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital to be eligible for ADvantage services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS ~~Appendix C-1 form 08AX001E~~, Schedule VIII. D.

(C) **Vendor payment.** For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, there is ~~no~~ not a spenddown calculation as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor payment obligation is met.

(D) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(3) **Individual with a spouse in the home who is not in the ADvantage or HCBW/MR program.** When only one individual of a couple in their own home is in the ADvantage or HCBW/MR program, income and resources are determined separately. However, the income and resources of the individual who is not in the ADvantage or HCBW/MR program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in ADvantage program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.

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- (i) If payment of income is made solely to one or the other, the income is considered available only to that individual.
- (ii) If payment of income is made to both, one-half is considered for each individual.
- (iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.
- (iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.
- (v) After determination of income, the gross income of the individual in the ADvantage program services cannot exceed the categorically needy standard in OKDHS ~~Appendix C-1 form 08AX001E~~, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the ADvantage program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving ADvantage program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving ADvantage program services, OKDHS Form 08MA012E, Title XIX Worksheet, is used.

- (i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the spouse into the ADvantage program services (regardless of payment source).
- (ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS ~~Appendix C-1 form 08AX001E~~, Schedule XI.
- (iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS ~~Appendix C-1 form 08AX001E~~, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or

exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving ADvantage program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving ADvantage program services cannot exceed the maximum resource standard for an individual as shown in OKDHS ~~Appendix C-1 form 08AX001E~~, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the ADvantage program service, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance is held within 30 days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

- (I) the community spouse's monthly income allowance;
- (II) the amount of monthly income otherwise available to the community spouse;
- (III) determination of the spousal share of resource;

- (IV) the attribution of resources (amount deemed); or
- (V) the determination of the community spouse's resource allowance.
- (x) The rules on determination of income and resources are applicable only when an individual receiving ADvantage program services is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the 30-day period ends.

(C) **Vendor payment.** For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, there is not a spenddown calculation for individuals receiving ADvantage program services as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, after allowable deeming to the community spouse, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor payment obligation is met.

(D) **Excess resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

[OAR Docket #10-559; filed 4-9-10]

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

[OAR Docket #10-578]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 17. ADvantage Waiver Services
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(Reference APA WF # 09-45)

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The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.180; 42 CFR 440.181

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N/A

ANALYSIS:
Rule revisions are needed to reflect the discontinuance of the administrative agent contract for the ADvantage Program between the Long Term Care Authority of Tulsa and the Oklahoma Department of Human Services. Formerly, the Oklahoma Department of Human Services contracted with the Long Term Care Authority of Tulsa to perform certain administrative functions related to the ADvantage Waiver. The Aging Services Division of the Oklahoma Department of Human Services has assumed those responsibilities and rule revisions are needed to correctly reflect the change. Rules are revised to increase the period of time allotted for the review and approval of the ADvantage waiver service plan authorization by the Oklahoma Department of Human Services Aging Services Division. Current limits do not allow for adequate time for the medical eligibility determination which could jeopardize federal funding thereby putting members at a greater risk for nursing facility placement.
CONTACT PERSON:
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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 MAY 13, 2010:

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-14. Case Management management services
(a) Case management services involve ongoing assessment, service planning and implementation, service monitoring and evaluation, client member advocacy, and discharge planning.
(1) Within one working day of receipt of an ADvantage referral from the ADvantage Administration (AA), the case management supervisor assigns a case manager to the client member. Within three working days of being

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assigned an ADvantage ~~client-member~~, the case manager makes a home visit to review the ADvantage program (its purpose, philosophy, and the roles and responsibilities of the ~~client member~~, service provider, case manager, ~~Administrative Agent AA~~ and OKDHS in the program), and review, update and complete the UCAT assessment, and to discuss service needs and ADvantage service providers. The Case Manager notifies in writing the ~~client's member's~~ UCAT identified primary physician that the ~~client member~~ has been determined eligible to receive ADvantage services. The notification is via a preprint form that contains the ~~client's member's~~ signed permission to release this health information and requests physician's office verification of primary and secondary diagnoses and diagnoses code obtained from the UCAT.

(2) ~~Within 10 working 14 calendar days of the receipt of an ADvantage referral, or the annual re-assessment visit,~~ the case manager completes and submits to the ~~case management-supervisor AA~~ an individualized care plan and service plan for the ~~client-member, signed by the member and the case management supervisor. The case manager completes and submits to the AA the annual reassessment service plan documents no sooner than 60 days before the existing service plan end date but sufficiently in advance of the end date to be received by the AA at least 30 calendar days before the end date of the existing service plan. Within 14 calendar days of receipt of a Service Plan Review Request (SPR) from the AA, the Case Manager provides corrected care plan and service plan documentation. Within five calendar days of assessed need, the case manager completes and submits a service plan addendum to the AA to amend current services on the care plan and service plan.~~ The care plan and service plan are based on the ~~client's-member's~~ service needs identified by the UCAT, Part III, and includes only those ADvantage services required to sustain and/or promote the health and safety of the ~~client-member~~. The case manager uses an interdisciplinary team (IDT) planning approach for care plan and service plan development. If in-home care is the primary service, the IDT includes, at a minimum, the ~~client member~~, a nurse from the ADvantage in-home care provider chosen by the ~~client member~~, and the case manager. Otherwise, the ~~client-member~~ and case manager constitute a minimum IDT.

(3) The case manager identifies long-term goals, challenges to meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The case manager identifies services, service provider, funding source, units and frequency of service and service cost, cost by funding source and total cost for ADvantage services. The ~~client-member~~ signs and indicates review/agreement with the care plan and service plan by indicating acceptance or non-acceptance of the plans. The ~~client member~~, the ~~client's-member's~~ legal guardian or legally authorized representative shall sign the service plan in the presence of the case manager. The signatures of two witnesses are required when the ~~client member~~ signs with a mark. If the ~~client member~~ refuses to cooperate in

development of the service plan, or, if the ~~client member~~ refuses to sign the service plan, the case management agency refers the case to the AA for resolution. In addition, based on the UCAT and/or case progress notes that document chronic uncooperative or disruptive behaviors, the LTC nurse or AA may identify ~~clients members~~ that require AA intervention.

(A) For ~~clients members~~ that are uncooperative or disruptive, the AA develops an individualized Addendum to the Rights and Responsibilities Agreement to try to modify the ~~client's member's~~ uncooperative/disruptive behavior. The ~~rights—Rights and responsibilities~~ Responsibilities Addendum focuses on behaviors, both favorable and those that jeopardize the ~~consumer's member's~~ well-being and includes a design approach of incremental plans and addenda that allow the ~~client-member~~ to achieve stepwise successes in the modification of their behavior.

(B) The AA may implement a service plan without the ~~client's member's~~ signature if the AA has developed an Addendum to the Rights and Responsibilities Agreement for the ~~client member~~. For these ~~clients members~~ the presence of a document that "requires" their signature may itself trigger a "conflict". In these circumstances, mental health/behavioral issues may prevent the ~~client member~~ from controlling their behavior to act in their own interest. Since the person by virtue of level of care and the IDT assessment, needs ADvantage services to assure their health and safety, the AA may implement the service plan if the AA demonstrates effort to work with and obtain the ~~client's member's~~ agreement through an individualized Addendum to the Rights and Responsibilities Agreement. Should negotiations not result in agreement with the care plan and service plan, the ~~client member~~ may withdraw their request for services or request a fair hearing.

(4) CD-PASS Planning and Supports Coordination.

(A) The ADvantage Case Management provider assigns to the CD-PASS ~~client-member~~ a Case Manager that has successfully completed training on CD-PASS, Independent Living Philosophy and ~~Person-centered-planning~~ Person-Centered Planning. Case Managers that have completed this specialized CD-PASS training are referred to as Consumer-Directed Agent/Case Managers (CDA/CM) with respect to their CD-PASS service planning and support role in working with CD-PASS ~~clients members~~. The CDA/CM educates the ~~client member~~ about their rights and responsibilities as well as about community resources, service choices and options available to the ~~client member~~ to meet CD-PASS service goals and objectives.

(B) The ~~client member~~ may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing ~~client-member~~ employer responsibilities. If the ~~client~~

member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the client member, the designee and the client's member's Case Manager or the AA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the client member has legal standing to be the client's member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a client member may not be designated the "authorized representative" for the client member.

(C) The CDA/CM provides support to the client member in the ~~Person-centered~~ Person-Centered CD-PASS ~~planning~~ Planning process. ~~Person-centered planning~~ Person-Centered Planning is a process directed by the participant, with assistance as needed from an "authorized representative" or support team. The process supports the client member to exercise choice and control and to assume a responsible role in developing, implementing and managing their services and supports. The process is intended to identify the strengths, capacities, preferences, needs and desired outcomes of the participant and it may enlist assistance from individuals freely chosen by the participant to serve as important contributors. The ~~person-centered planning~~ Person-Centered Planning process enables the participant to identify and access a personalized mix of paid and non-paid services and supports to help him/her achieve personally-defined outcomes in the most inclusive community setting. The focus of ~~person-center~~ planning Person-Centered Planning is on the individual's development of personal relationships, positive roles in community activities, and self-empowerment skills. Decisions are made and outcomes controlled by the participant. Strengths, preferences and an individualized system of support are identified to assist the individual to achieve functional and meaningful goals and objectives. Principles of Person-Centered Planning are as follows:

(i) The person is the center of all planning activities.

(ii) The client member and their representative, or support team, are given the requisite information to assume a controlling role in the development, implementation and management of the client's member's services.

(iii) The individual and those who know and care about him or her are the fundamental sources of information and decision-making.

(iv) The individual directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals and support needs.

(v) ~~Person-centered planning~~ Person-Centered Planning results in personally-defined outcomes.

(D) The CDA/CM encourages and supports the client member, or as applicable their designated "authorized representative", to lead, to the extent feasible, the CD-PASS service planning process for Personal Services Assistance. The CDA/CM helps the client member define support needs, service goals and service preferences including access to and use of generic community resources. Consistent with ~~client direction~~ member-direction and preferences, the CDA/CM provides information and helps the client member locate and access community resources. Operating within the constraints of the Individual Budget Allocation (IBA) units, the CDA/CM assists the client member in translating the assessment of client member needs and preferences into an individually tailored, personalized service plan.

(E) To the extent the client member prefers, the CDA/CM develops assistance to meet client member needs using a combination of traditional Personal Care and CD-PASS PSA services. However, the CD-PASS IBA and the PSA unit authorization will be reduced proportional to agency Personal Care service utilization.

(F) The client member determines with the PSA to be hired, a start date for PSA services. The client member coordinates with the CDA/CM to finalize the service plan.

(G) Based on outcomes of the planning process, the CDA/CM prepares an ADvantage service plan or plan amendment to authorize CD-PASS Personal Service Assistance units consistent with this individual plan and notifies existing duplicative Personal Care service providers of the end date for those services.

(H) If the plan requires an APSA to provide assistance with Health Maintenance activities, the CDA/CM works with the client member and, as appropriate, arranges for training by a skilled nurse for the client member or client's member's family and the APSA to ensure that the APSA performs the specific Health Maintenance tasks safely and competently;

(i) If the client's member's APSA has been providing Advanced Supportive Restorative Assistance to the client member for the same tasks in the period immediately prior to being hired as the PSA, additional documentation of competence is not required;

(ii) If the client member and APSA attest that the APSA has been performing the specific Health Maintenance tasks to the client's member's satisfaction on an informal basis as a friend or family member for a minimum of two months in the period immediately prior to being hired as the PSA, and no evidence contra-indicates the attestation of safe and competent performance by the APSA, additional documentation is not required.

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(I) The CDA/CM monitors the client's member's well being and the quality of supports and services and assists the client member in revising the PSA services plan as needed. If the client's member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the CDA/CM, based upon an updated assessment, amends the service plan to increase CD-PASS service units appropriate to meet additional client member's need and forwards the plan amendment to the AA for authorization and update of the client's member's IBA.

(J) The CDA/CM uses the ADvantage Risk Management process the results of which are binding on all parties to resolve service planning or service delivery disagreements between clients members and ADvantage service providers under the following circumstances:

(i) A claim is formally registered with the CDA/CM by the client member (or the client's member's family or "authorized representative"), the AA, or a provider that the disagreement poses a significant risk to the client's member's health or safety; and

(ii) The disagreement is about a service, or about the appropriate ~~frequency~~ frequency, duration or other aspect of the service; or

(iii) The disagreement is about a behavior/action of the client member, or about a behavior/action of the provider.

(K) The CDA/CM and the client member prepare an emergency ~~back up/emergency backup/emergency~~ response capability for CD-PASS PSA services in the event a PSA provider of services essential to the individual's health and welfare fails to deliver services. As part of the planning process, the CDA/CM and client member define what failure of service or neglect of service tasks would constitute a risk to health and welfare to trigger implementation of the emergency backup. Any of the following may be used in planning for the backup:

(i) Identification of a qualified substitute provider of PSA services and preparation for their quick response to provide backup services when called upon in emergency circumstances (including execution of all qualifying background checks, training and employment processes); and/or,

(ii) Identification of one or more qualified substitute ADvantage agency service providers (Adult Day Care, Personal Care or Nursing Facility Respite provider) and preparation for their quick response to provide backup services when called upon in emergency circumstances.

(L) If the emergency backup fails, the CDA/CM is to request the AA to authorize and facilitate client member access to Adult Day Care, Agency Personal Care or Nursing Facility Respite services.

(5) The case manager submits the care plan and service plan to the case management supervisor for review. The case management supervisor documents the review/approval of the plans within two working days of receipt from the case manager or returns the plans to the case manager with notations of errors, problems, and concerns to be addressed. The case manager re-submits the corrected care plan and service plan to the case management supervisor within two working days. The case management supervisor returns the approved care plan and service plan to the case manager. Within one working day of receiving supervisory approval, the case manager ~~makes a copy of the plans and other client forwards, via postal mail, a legible copy of the care plan and service plan~~ to the AA. Case managers are responsible for retaining all original documents for the client member's file, faxes a copy of the plan to the AA and forwards the original care plan and service plan and required documents at the agency. Only priority service needs and supporting documentation may be faxed to the AA with the word, "PRIORITY" being clearly indicated and the justification attached. "Priority" service needs are defined as services needing immediate authorization to protect the health and welfare of the member and/or avoid premature admission to the nursing facility. Corrections to service conditions set by the AA are not considered to be a priority unless the health and welfare of the member would otherwise be immediately jeopardized and/or the member would otherwise require premature admission to a nursing facility.

(6) Within one working day of notification of care plan and service plan authorization, the case manager communicates with the service plan providers and with the client member to facilitate service plan implementation. Within one working day of receipt of a copy or the computer-generated authorized service plan from the AA, the case manager sends (by mail or fax) copies of the authorized service plan or computer-generated copies to providers. Within five working days of notification of an initial or new service plan authorization, the case manager visits the client member, gives the client member a copy of the service plan or computer-generated copy of the service plan and evaluates the progress of the service plan implementation. The case manager evaluates service plan implementation on the following minimum schedule:

(A) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and

(B) monthly after the initial 30 day follow-up evaluation date.

(b) **Authorization of service plans and amendments to service plans.** The ~~Administrative Agent~~ ADvantage Administration (AA) certifies the individual service plan and all service plan amendments for each ADvantage client member. When the AA verifies client member ADvantage eligibility, plan cost effectiveness, that service providers are ADvantage authorized and ~~Medicaid~~ SoonerCare contracted, and that the delivery of ADvantage services are consistent with the

client's member's level of care need, the service plan is authorized. Except as provided by the process described in OAC 317:30-5-761(6), family members may not receive payment for providing ADvantage waiver services. A family member is defined as an individual who is legally responsible for the client member (spouse or parent of a minor child).

(1) If the service plan authorization or amendment request packet received from case management is complete and the service plan is within cost effectiveness guidelines, the AA authorizes or denies authorization within ~~three~~ five working days of receipt of the request. If the service plan authorization or amendment request packet received from case management is complete and the service plan is not within cost-effectiveness guidelines, the plan is referred for administrative review to develop an alternative cost-effective plan or assist the client member to access services in an alternate setting or program. If the request packet is not complete, the AA notifies the case manager immediately and puts a "hold" on authorization until the required additional documents are received from case management.

(2) The AA authorizes the service plan by entering the authorization date and signing the submitted service plan. Notice of authorization and a copy of the authorized plan or a computer-generated copy of the authorized plan are provided to case management. AA authorization determinations are provided to case management within one working day of the certification date. A service plan may be authorized and implemented with specific services temporarily denied. The AA communicates to case management the conditions for approval of temporarily denied services. The case manager submits revisions for denied services to AA for approval.

(3) For audit purposes (including SURS reviews), the computer-generated copy of the authorized service plan is documentation of service authorization for ADvantage waiver and State Plan Personal Care services. State or Federal quality review and audit officials may obtain a copy of specific service plans with original signatures by submitting a request to the AA.

(c) **Change in service plan.** The process for initiating a change in the service plan is described in this subsection.

(1) The service provider initiates the process for an increase or decrease in service to the client's member's service plan. The requested changes and justification for them are documented by the service provider and, if initiated by a direct care provider, submitted to the client's member's case manager. If in agreement, the case manager requests the service changes on a care plan and service plan amendment submitted to the AA within five calendar days of assessed need. The AA approves or denies the care plan and service plan changes within ~~two~~ working five calendar days of receipt of the plan.

(2) The client member initiates the process for replacing Personal Care services with Consumer-Directed Personal Services and Supports (CD-PASS) in geographic areas in which CD-PASS services are available. The client member may contact the AA using a CD-PASS services request form provided by the Case Manager or by calling

the toll-free number established to process requests for CD-PASS services.

(3) A significant change in the client's member's physical condition or caregiver support, one that requires additional goals, deletion of goals or goal changes, or requires a four-hour or more adjustment in services per week, requires a UCAT reassessment by the case manager. The case manager, in consultation with AA, makes the determination of need for reassessment. Based on the reassessment and consultation with the AA, the client member may, as appropriate, be authorized for a new service plan or be eligible for a different service program. If the client member is significantly improved from the previous assessment and does not require ADvantage services, the case manager obtains the client's member's dated signature indicating voluntary withdrawal for ADvantage program services. If unable to obtain the client's member's consent for voluntary closure, the case manager requests assistance from the AA. The AA requests that the OKDHS area nurse initiate a reconsideration of level of care. If the client's member's service needs are different or have significantly increased, the case manager develops an amended or new service plan and care plan, as appropriate, and submits the new/amended plans for authorization.

[OAR Docket #10-578; filed 4-9-10]

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

[OAR Docket #10-566]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 5. Member Services
Part 1. Agency Companion Services
317:40-5-5. [AMENDED]
(Reference APA WF # 09-21)

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N/A

ANALYSIS:

Rule revisions are needed to correct policy references regarding responsibilities of Agency Companion Services provided to the developmentally disabled. Without the rule change reference corrections, the potential for oversight of incident reporting and quality assurance is increased, resulting in a lower over-all quality of care for the developmentally disabled through Agency Companion Services.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 MAY 13, 2010:

SUBCHAPTER 5. MEMBER SERVICES

PART 1. AGENCY COMPANION SERVICES

317:40-5-5. Agency Companion Services provider responsibilities

(a) Providers of Agency Companion Services (ACS) are required to meet all applicable standards outlined in this subchapter and competency-based training described in OAC 340:100-3-38. The provider agency ensures that all companions meet the criteria in this Section.

(b) Failure to follow any rules or standards, failure to promote the independence of the member, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, as described in subsection (b) of OAC 340:100-3-27, for the companion, and if warranted, revocation of approval of the companion.

(c) In addition to the criteria given in OAC 317:40-5-4, the companion:

(1) ensures no other adult or child is cared for in the home on a regular or part-time basis including other Oklahoma Department of Human Services (OKDHS) placements, family members, and friends without prior written authorization from the OKDHS Developmental Disabilities Services Division (DDSD) area manager or designee;

(2) meets the requirements of OAC 317:40-5-103, Transportation. Neither the companion nor the provider

agency may claim transportation reimbursement for vacation travel;

(3) transports or arranges transportation for the member to and from school, employment programs, recreational activities, medical appointments, and therapy appointments;

(4) delivers services in a manner that contributes to the member's enhanced independence, self sufficiency, community inclusion, and well-being;

(5) participates as a member of the member's Team and assists in the development of the member's Individual Plan for service provision;

(6) with assistance from the DDSD case manager and the provider agency program coordination staff, develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the companion is responsible, as identified in the Individual Plan;

(A) The companion documents and provides monthly data and health care summaries to the provider agency program coordination staff.

(B) The agency staff provides monthly reports to the DDSD case manager or nurse.

(7) delivers services at appropriate times as directed in the Individual Plan;

(8) does not deliver services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals with Disabilities Education Act (IDEA);

(9) is sensitive to and assists the member in participating in the member's chosen religious faith. No member is expected to attend any religious service against his or her wishes;

(10) participates in and supports visitation and contact with the member's natural family, guardian, and friends, provided this visitation is desired by the member;

(11) obtains permission from the member's legal guardian, if a guardian is assigned, and notifies the family, the provider agency program coordination staff, and the case manager prior to:

(A) traveling out of state;

(B) overnight visits; or

(C) involvement of the member in any publicity;

(12) serves as the member's health care coordinator in accordance with OAC 340:100-5-26;

(13) ensures the monthly room and board contribution received from the member as reflected on OKDHS Form 06AC074E, Service Authorization Budget (SAB), is used toward the cost of operating the household;

(14) assists the member in accessing entitlement programs for which the member may be eligible and maintains records required for the member's ongoing eligibility;

(15) works closely with the provider agency program coordination staff and the DDSD case manager to ensure all aspects of the member's program are implemented to the satisfaction of the member, the member's family or legal guardian, when appropriate, and the member's Team;

- (16) assists the member in achieving the member's maximum level of independence;
- (17) submits, in a timely manner, to the provider agency program coordination staff all necessary information regarding the member;
- (18) ensures that the member's confidentiality is maintained in accordance with OAC 340:100-3-2;
- (19) supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;
- (20) implements training and provides supports that enable the member to actively join in community life;
- (21) does not serve as representative payee for the member without a written exception approval from the DDS area manager or designee;
 - (A) The written approval is retained in the member's home record.
 - (B) When serving as payee, the companion complies with the requirements of OAC 340:100-3-4.
- (22) ensures the member's funds are properly safeguarded.
- (23) must obtain prior approval from the provider agency when making a purchase of over \$50.00 with the member's funds;
- (24) allows the provider agency staff and DDS staff to make announced and unannounced visits to the home;
- (25) develops an Evacuation Plan, OKDHS Form 06AC020E, for the home and conducts training with the member;
- (26) conducts fire and weather drills at least quarterly and maintains the Fire and Weather Drill Record, OKDHS Form 06AC021E, available for review;
- (27) develops and maintains a Personal Possession Inventory, OKDHS Form 06AC022E, documenting the member's possessions and adaptive equipment;
- (28) supports the member's employment program by:
 - (A) assisting the member to wear appropriate work attire; and
 - (B) contacting the member's employer only as outlined by the Team and in the Individual Plan; and
- (29) follows all applicable rules promulgated by the Oklahoma Health Care Authority or DDS, including:
 - (A) OAC 340:100-3-40;
 - (B) OAC 340:100-5-50 through 100-5-58;
 - (C) OAC 340:100-5-26;
 - (D) OAC 340:~~100-5-34~~ 100-3-34;
 - (E) OAC 340:100-5-32;
 - (F) OAC 340:100-5-22.1;
 - (G) OAC 340:~~100-3-24~~ 100-3-27; and
 - (H) OAC 340:100-3-38.

[OAR Docket #10-566; filed 4-9-10]

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

[OAR Docket #10-579]

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Subchapter 9. Self-Directed Services [NEW]

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ANALYSIS:

Agency rules are issued to allow for SoonerCare members receiving services through the In-Home Supports Waivers, the option to self-direct those services. Self-direction allows a greater freedom of choice and is proven to be a more efficient and cost effective method of service delivery. Under the self-directed services program, each member is given a set budget amount and is given the opportunity to decide which goods and services provide the best outcomes for his/her quality of life. During this time of shrinking state budgets, the necessity to operate programs in a more efficient manner is of paramount importance.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 MAY 13, 2010:

Permanent Final Adoptions

SUBCHAPTER 9. SELF-DIRECTED SERVICES

317:40-9-1. Self-Directed Services (SDS)

(a) **Applicability.** The rules in this section apply to self-directed services provided through Home and Community Based Service (HCBS) Waivers operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD).

(b) **Member Option.** Traditional service delivery methods are available for eligible members who do not elect to self-direct their services.

(c) **General Information.** Self-Direction is an option for members receiving Home and Community Based Services (HCBS) through the In-Home Supports Waiver for Adults (IHSW-A) or the In-Home Supports Waiver for Children (IHSW-C). Self-Direction provides the opportunity for a member to exercise choice and control in identifying, accessing, and managing specific waiver services and supports in accordance with their needs and personal preferences. Self-Directed Services (SDS) are Waiver services that the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) specifies may be directed by the member or representative using both employer and budget authority.

(1) Services may be directed by:

(A) an adult member, if the member has the ability to self-direct; or

(B) a legal representative of the member, including a parent, spouse or legal guardian; or

(C) a non-legal representative freely chosen by the member or their legal representative.

(2) The person directing services must:

(A) be 18 years of age or older;

(B) comply with OKDHS/DDSD and Oklahoma Health Care Authority (OHCA) rules and regulations;

(C) complete required OKDHS/DDSD training for self-direction;

(D) sign an agreement with OKDHS/DDSD;

(E) be approved by the member or their legal representative to act in the capacity of a representative; and

(F) demonstrate knowledge and understanding of the member's needs and preferences.

(d) **SDS program includes:**

(1) **SDS Budget.** A plan of care is developed to meet the member's needs without consideration of SDS. The member may elect to self-direct part or all of the amount identified for traditional Habilitation Training Specialist (HTS) services. This amount is under the control and discretion of the member in accordance with this policy and the approved IHSW, and is the allocated amount which may be used to develop the SDS budget. The SDS budget details the specific plan for spending.

(A) A SDS budget is developed annually at the time of the annual plan development and updated as necessary by the member, case manager, parent, legal guardian, and others the member invites to participate in the development of the budget.

(B) Payment may only be authorized for goods and services not covered by SoonerCare or other generic funding sources, and meets the criteria of service necessity per OAC 340:100-3-33.1.

(C) The member's SDS budget includes the actual cost of administrative activities including fees for services performed by a Financial Management Services (FMS) subagent, background checks, workers compensation insurance and the amount identified for SD-HTS and SD-GS.

(D) The SDS budget is added to the plan of care to replace any portion of traditional HTS services to be self-directed.

(2) The SD-Habilitation Training Specialist (SD-HTS) supports the member's self-care, daily living and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion and well-being. SD-HTS must be included in the approved SDS budget. Payment will not be made for routine care and supervision that is normally provided by a family member or the member's spouse. SD-HTS are provided only during periods when staff is engaged in purposeful activity that directly or indirectly benefits the member. At no time are SD-HTS services authorized for periods during which the staff are allowed to sleep. Legally responsible persons may not provide services per OAC 340:100-3-33.2. Other family members providing services must be employed by provider agencies per OAC 340:100-3-33.2. Payment does not include room and board, maintenance, upkeep or improvements to the member's or family's residence. A SD-HTS must:

(A) be 18 years of age;

(B) pass a background check per OAC 340:100-3-39;

(C) demonstrate competency to perform required tasks;

(D) complete required training per OAC 340:100-3-38.5;

(E) sign an agreement with OKDHS/DDSD and the member;

(F) be physically able and mentally alert to carry out the duties of the job;

(G) not work more than 40 hours in any week in the capacity of a SD-HTS; and

(H) not implement restrictive or intrusive procedures per OAC 340:100-5-57.

(3) Self-Directed Goods and Services (SD-GS). SD-GS are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care. These goods and services must be included in the individual plan and approved SDS budget. SD-GS must meet the following requirements:

- (A) The item or service is justified by a recommendation from a licensed professional.
- (B) The item or service is not prohibited by Federal and State statutes and regulations.
- (C) One or more of the following additional criteria are met:
 - (i) the item or service would increase the member's functioning related to the disability;
 - (ii) the item or service would increase the member's safety in the home environment; or
 - (iii) the item or service would decrease dependence on other SoonerCare funded services.
- (D) SD-GS may include, but are not limited to:
 - (i) fitness items that can be purchased at most retail stores;
 - (ii) personal emergency monitoring systems;
 - (iii) food catcher;
 - (iv) specialized swing set;
 - (v) toothettes or electric toothbrush;
 - (vi) seat lift;
 - (vii) weight loss program; or
 - (viii) gym memberships when there is an identified need for weight loss or increased physical activity.
- (E) SD-GS may not be used for:
 - (i) co-payments for medical services;
 - (ii) over-the-counter medications;
 - (iii) items or treatments that have not been approved by the Food and Drug Administration;
 - (iv) homeopathic services;
 - (v) services available through any other funding source such as SoonerCare, Medicare, private insurance, public school system, Rehabilitation Services or natural supports;
 - (vi) room and board, including deposits, rent and mortgage payments;
 - (vii) personal items and services not directly related to the member's disability;
 - (viii) vacation expenses;
 - (ix) insurance;
 - (x) vehicle maintenance or any other transportation related expense;
 - (xi) costs related to internet access;
 - (xii) clothing;
 - (xiii) tickets and related costs to attend recreational events;
 - (xiv) services, goods or supports provided to or benefiting persons other than the member; or
 - (xv) experimental goods or services.
- (F) SD-GS are reviewed and approved by DDS division director or designee.
- (e) **Member Responsibilities.** When the member chooses the SDS option, the member or member's representative is the employer of record and must:
 - (1) enroll and complete the OKDHS/DDSD sanctioned training course in self-direction. The training must be completed prior to the implementation of self-direction and will cover the following areas:
 - (A) staff recruitment;
 - (B) hiring of staff as employer of record;
 - (C) orientation and instruction of staff in duties consistent with approved specifications;
 - (D) supervision of staff including scheduling and service provisions;
 - (E) evaluation of staff;
 - (F) discharge of staff;
 - (G) philosophy of self-direction;
 - (H) OHCA policy on self-direction;
 - (I) individual budgeting;
 - (J) development of a self-directed support plan;
 - (K) cultural diversity; and
 - (L) rights, risks, and responsibilities.
 - (2) sign an agreement with OKDHS/DDSD;
 - (3) agree to utilize the services of a FMS subagent;
 - (4) agree to pay administrative costs for background checks, FMS subagent fee, and worker's compensation insurance from their SDS budget;
 - (5) comply with federal and state employment laws and ensure no employee works more than 40 hours per week in the capacity of SD-HTS;
 - (6) ensure that each employee is qualified to provide the services for which he/she is employed and that all billed services are actually provided;
 - (7) ensure that each employee complies with all OKDHS/DDSD training requirements for In-Home Support Waivers per OAC 340:100-3-38.5;
 - (8) recruit, hire, supervise, and discharge when necessary all employees providing self-directed services;
 - (9) verify employee qualifications;
 - (10) obtain a background screening on all employees providing SD-HTS per OAC 340:100-3-39;
 - (11) send monthly progress reports to the case manager by the 10th of each month for the preceding month of service via mail, e-mail or personal delivery.
 - (12) participate in the Individual Plan and SDS budget process;
 - (13) immediately notify the case manager of any changes in circumstances or emergencies, which may require modification of the type or amount of services provided for in the member's Individual Plan or SDS budget;
 - (14) wait for approval of budget modifications before implementing changes;
 - (15) comply with OKDHS/DDSD and OHCA administrative rules;
 - (16) cooperate with OKDHS/DDSD monitoring requirements per OAC 340:100-3-27;
 - (17) cooperate with all requirements of the FMS subagent to ensure accurate records and prompt payroll including:
 - (A) reviewing and signing employee time cards;
 - (B) verifying the accuracy of hours worked; and
 - (C) ensuring the appropriate expenditure of funds.
 - (18) complete all required documents within established timeframes;

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- (19) pay for services incurred in excess of the budget amount;
- (20) pay for services not identified and approved in the member's SDS budget;
- (21) pay for services provided by an unqualified provider;
- (22) determine staff duties, qualifications, and specify service delivery practices consistent with SD-HTS waiver service specifications;
- (23) orient and instruct staff in duties;
- (24) evaluate staff performance;
- (25) identify and train back-up staff when required;
- (26) determine amount paid for services within Plan limits;
- (27) schedule staff and the provision of services;
- (28) ensure SD-HTS do not implement restrictive or intrusive procedures per OAC 340:100-5-57; and
- (29) sign an agreement with OKDHS/DDSD and the SD-HTS.
- (f) **Financial Management Services (FMS) subagent responsibilities.** The FMS subagent is an entity designated as an agent by OKDHS/DDSD to act on behalf of members who have employer and budget authority for the purpose of managing payroll tasks for the member's employee(s) and for making payment of SD-GS as authorized in the member's Plan. FMS subagent duties include, but are not limited to:
- (1) compliance with all OKDHS/DDSD and OHCA administrative rules and contract requirements;
- (2) compliance with random and targeted audits conducted by OKDHS/DDSD or the OHCA;
- (3) provision of financial management support to the member by tracking individual expenditures and monitoring SDS budgets;
- (4) processing the member's employee payroll, withholding, filing and paying of applicable federal, state and local employment-related taxes and insurance;
- (5) collection and process of employee's time sheets and making payment to member's employees;
- (6) processing and payment of invoices for SD-GS as authorized in the member's SDS budget;
- (7) providing each member with information that will assist with managing the SDS budget;
- (8) providing reports to members/representatives, as well as OKDHS/DDSD monthly and to OHCA upon request;
- (9) providing OKDHS/DDSD and OHCA authorities access to individual member's accounts through a web-based program;
- (10) assisting members in verifying employee citizenship status;
- (11) maintaining separate accounts for each member's SDS budget;
- (12) tracking and reporting member funds, disbursements and the balance of member funds;
- (13) receiving and disbursing funds for the payment of SDS under an agreement with the OHCA; and
- (14) executing and maintaining contractual agreement between OKDHS/DDSD and the SD-HTS (employee).
- (g) **OKDHS/DDSD Case Management responsibilities in support of SDS.**
- (1) The case manager develops the member's Plan per OAC 340:100-5-50 through 58;
- (2) The DDSD case manager meets with the member and/or the member's representative or legal guardian to discuss the following service delivery options in the HCBS Waiver:
- (A) traditional Waiver services; and
- (B) self-directed services including information regarding scope of choices, options, rights, risks, and responsibilities associated with self-direction.
- (3) If the member chooses self-direction, the case manager will:
- (A) discuss with member or representative the amount available in the budget;
- (B) assist member or representative with the development and modification of the SDS budget;
- (C) submit request for SD-GS to the DDSD division director or designee for review and approval prior to the case manager's approval of the SDS budget;
- (D) approve the SDS budget and modifications;
- (E) assist member or representative with developing or revising an emergency back-up plan;
- (F) provide FMS subagent a copy of the member's authorized SDS budget and any modifications;
- (G) monitor implementation of the Plan per OAC 340:100-3-27.
- (H) ensure that services are initiated within required time frames;
- (I) conduct ongoing monitoring of the implementation of the Plan and the member's health and welfare;
- (J) specify additional employee qualifications in the Plan based on the member's needs and preferences so long as such qualifications are consistent with approved waiver qualifications;
- (K) specify in the Plan how services are provided;
- (L) refer potential SD-HTS providers to the FMS subagent for enrollment;
- (M) assist in locating and securing services and other community resources that promote community integration, community membership and independence, as provided in the member's Plan; and
- (N) ensure any restrictive or intrusive procedures per OAC 340:100-5-57 are not implemented by the SD-HTS. If the Team determines restrictive or intrusive procedures are necessary, SD-HTS is not appropriate to meet the needs of the member and traditional services must be used.
- (h) **Government Fiscal/Employer Agent Model.** OKDHS/DDSD serves as the Organized Health Care Delivery System (OHCDS) as well as the FMS provider in a Centers for Medicare and Medicaid Services (CMS) approved Government Fiscal/Employer Agent model. OKDHS/DDSD has an interagency agreement with OHCA.
- (i) **Voluntary Termination of Self-Directed Services.** Members may discontinue self-directing services without

disruption at any time, provided traditional waiver services are in place. Members or representatives may not choose the self-directed option again until the next annual planning meeting, with services resuming no earlier than the beginning of the next plan of care. Any member desiring to file a complaint must follow the procedures set forth by OKDHS at OAC 340:2-5-61.

(j) Involuntary Termination of Self-Directed Services.

(1) Members may be terminated involuntarily from self-direction and offered traditional waiver services when it has been determined by OKDHS/DDSD Director or designee that any of the following exist:

(A) immediate health and safety risks associated with self-direction, such as, imminent risk of death or irreversible or serious bodily injury related to waiver services;

(B) intentional misuse of funds following notification, assistance and support from OKDHS/DDSD;

(C) failure to follow and implement policies of self-direction after technical assistance and guidance from OKDHS/DDSD;

(D) fraud; or

(E) it is determined that restrictive or intrusive procedures are essential for safety.

(2) When action is taken to terminate the member from self-directed services involuntarily, the case manager assists the member in accessing needed and appropriate services through the traditional waiver services option, ensuring that no lapse in necessary services occurs for which the member is eligible.

(3) The Fair Hearing process as described in OAC 340:100-3-13 applies.

(k) Reporting requirements. While operating as an Organized Health Care Delivery System, OKDHS/DDSD will provide to the OHCA reports detailing provider activity in the format and at such times as required by the OHCA.

[OAR Docket #10-579; filed 4-9-10]

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

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SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 11. Insure Oklahoma/O-EPIC IP
Part 3. Insure Oklahoma/O-EPIC Member Health Care Benefits
317:45-11-11. [AMENDED]

Gubernatorial approval:

July 21, 2009

Register publication:

26 Ok Reg 3035

Docket number:

09-1216

(Reference APA WF # 09-27)

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rule revisions are needed to clarify the intent of non-covered benefits related to weight loss treatment and intervention including bariatric surgical procedures. The rule revision will make rules consistent with reimbursement practices and clarify coverage and access to healthcare for Oklahomans, thereby reducing confusion among individuals enrolled in the IP program about covered benefits and ultimately reducing the amount of uncompensated care provided by healthcare providers.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 MAY 13, 2010:

SUBCHAPTER 11. INSURE OKLAHOMA/O-EPIC IP

PART 3. INSURE OKLAHOMA/O-EPIC IP MEMBER HEALTH CARE BENEFITS

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

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

- (1) services that the member's PCP or Insure Oklahoma/O-EPIC does not consider medically necessary;

- (2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
- (3) organ and tissue transplant services;
- (4) treatment of obesity weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;
- (5) procedures, services and supplies related to sex transformation;
- (6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
- (7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
- (8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
- (9) experimental procedures, drugs or treatments;
- (10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) except for pregnant women and as covered in OAC 317:30-5-696;
- (11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
- (12) physical medicine including chiropractic, acupuncture and osteopathic manipulation therapy;
- (13) hearing services;
- (14) transportation [emergent or non-emergent (air or ground)];
- (15) rehabilitation (inpatient);
- (16) cardiac rehabilitation;
- (17) allergy testing and treatment;
- (18) home health care with the exception of medications, intravenous (IV) therapy, supplies;
- (19) hospice regardless of location;
- (20) Temporomandibular Joint Dysfunction (TMD) (TMJ);
- (21) genetic counseling;
- (22) fertility evaluation/treatment/and services;
- (23) sterilization reversal;
- (24) Christian Science Nurse;
- (25) Christian Science Practitioner;
- (26) skilled nursing facility;
- (27) long-term care;
- (28) stand by services;
- (29) thermograms;
- (30) abortions (for exceptions, refer to OAC 317:30-5-6);
- (31) services of a Lactation Consultant;
- (32) services of a Maternal and Infant Health Licensed Clinical Social Worker; and
- (33) enhanced services for medically high risk pregnancies as found in OAC 317:30-5-22.1.

[OAR Docket #10-569; filed 4-9-10]

TITLE 340. DEPARTMENT OF HUMAN SERVICES

CHAPTER 1. FUNCTION AND STRUCTURE OF THE DEPARTMENT

[OAR Docket #10-456]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions

340:1-1-17 [AMENDED]

(Reference APA WF 09-22)

AUTHORITY:

Commission for Human Services, Article XXV, Sections 2 and 4 of the Oklahoma Constitution; and Sections 250 et seq. of Title 75 of the Oklahoma Statutes.

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None requested

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n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

Subchapter 1 of Chapter 1 proposed rule revisions reflect current names of divisions within Oklahoma Department of Human Services (OKDHS).

CONTACT PERSON:

Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

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 MAY 13, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

340:1-1-17. Organizational structure

(a) **Commission for Human Services (Commission).** The Oklahoma Department of Human Services (OKDHS) is governed by a nine-member Commission. Each Commissioner is appointed by the Governor of Oklahoma to serve a nine-year term. The Commission selects a Director of Human Services (Director) who is responsible for oversight of OKDHS.

(b) **Organizational chart.** OKDHS is organized as the Director and Commission deem desirable to carry out the OKDHS mission. Organizational charts are available upon request to Administrative Services.

(c) **Offices and divisions within the OKDHS.** The functions of the offices and divisions within OKDHS are outlined in this subsection.

(1) **Administrative Services.** The chief administrative officer serves as coordinator of the administrative divisions within OKDHS and provides oversight of divisions that report directly to the Director. Administrative divisions under Administrative Services are:

- (A) Human Resources Management Division (HRMD);
- (B) Support Services Division (SSD);
- (C) Office of Communications;
- (D) Office of Volunteerism;
- (E) Office of Information and Referral;
- (F) Office of ~~Legislative~~ Intergovernmental Relations and Policy (~~OLR~~ POIRP); and
- (G) the divisions responsible for the functions that report directly to the Director, which are:
 - (i) Office of Client Advocacy;
 - (ii) Office of Inspector General; and
 - (iii) Office for Civil Rights.

(2) **Legal Division.** The general counsel serves as the coordinator of the Legal Division and as chief legal counsel to the Commission and the Director.

(3) **Human Services Centers.** The chief operating officer serves as coordinator of services delivered through offices in each county. Divisions within the Human Services Centers are:

- (A) Family Support Services Division (FSSD);
- (B) Children and Family Services Division (CFSD); and
- (C) Field Operations Division (FOD).

(4) **Information Services Divisions.** The chief information officer serves as coordinator of OKDHS information technology. Divisions and offices within information services are:

- (A) Data Services Division (DSD);
- (B) Office of Planning, Research, and Statistics (OPRS);
- (C) Enterprise Project Management Office; and
- (D) Information Security Office.

(5) **Financial services.** The chief financial officer serves as coordinator of the Finance Division and is responsible for the coordination of OKDHS financial services.

(6) **Vertically Integrated Services Divisions.** The chief coordinating officer serves as coordinator of program divisions, which have vertically integrated administrations. For example, field staff and program design staff are under the same administrative structure. Divisions included in the vertically integrated services are:

- (A) Aging Services Division (ASD);
- (B) ~~Division of Oklahoma~~ Child Care Services (~~CCOCCS~~);

- (C) ~~Oklahoma Child Support Enforcement Division~~ Services (~~CSEDOCCS~~); and
- (D) Development Disabilities Services Division (DDSD).

[OAR Docket #10-456; filed 3-31-10]

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

[OAR Docket #10-457]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. Human Resources Management Division (HRMD)
Part 5. Administrative Procedures
340:2-1-58 [AMENDED]
(Reference APA WF 09-21)

AUTHORITY:

Commission for Human Services, Article XXV, Sections 2 and 4 of the Oklahoma Constitution; and Section 840-2.20A of Title 74 of the Oklahoma Statutes.

DATES:

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n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The proposed revisions to Subchapter 1 of Chapter 2 amend rules to: (1) clarify how Oklahoma Department of Human Services (OKDHS) will operate and deliver services to the citizens of Oklahoma during hazardous weather conditions and temporary office closings due to imminent peril or unsafe conditions; and (2) remove language that is internal OKDHS procedures.

CONTACT PERSON:

Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

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 MAY 13, 2010:

Permanent Final Adoptions

SUBCHAPTER 1. HUMAN RESOURCES MANAGEMENT DIVISION (HRMD)

PART 5. ADMINISTRATIVE PROCEDURES

340:2-1-58. Reduced services or and temporary office or facility closures

(a) ~~Absences due to hazardous weather conditions.~~ Reduction of services and authorized absences may be granted to Oklahoma Department of Human Services (OKDHS) employees designated not responsible for staffing essential functions during periods of hazardous weather, which may threaten the safety of employees. [OAC 530:10-15-72]

(1) ~~Reduction of services due to hazardous weather conditions.~~ Decisions concerning reduction of services is based Based on information obtained from the Office of Personnel Management (OPM) and authorization received from the Oklahoma Department of Public Safety (DPS), and authorized by the Secretary of Safety and Security the Oklahoma Department of Human Services (OKDHS) may reduce services available to clients during hazardous weather conditions.

(A) ~~Employees responsible for staffing essential OKDHS functions.~~ OKDHS is responsible for maintaining its essential functions and client services regardless of weather conditions. Employees designated as responsible for staffing essential OKDHS functions are not eligible for enforced leave for absences due to hazardous weather conditions and are charged either annual leave or leave without pay as appropriate. Neither are OKDHS Fair Labor Standards Act (FLSA) non-exempt employees responsible for staffing essential functions authorized to use compensatory time or a workweek adjustment for absences during hazardous weather conditions. Employees designated as staffing essential OKDHS functions and who are to report for duty are:

(2) Services provided by OKDHS hot lines, institutions, shelters, and other residential care facilities are not reduced during hazardous weather conditions.

- (i) ~~all employees of all institutions, shelters, group homes, and other residential care facilities;~~
- (ii) ~~all supervisory employees for county and area offices, unless otherwise designated by the division director;~~
- (iii) ~~all OKDHS Executive Team members;~~
- (iv) ~~senior staff for state office locations, unless otherwise designated by the division director; and~~
- (v) ~~other employees as designated in writing by the OKDHS Director or appropriate senior administrator or division director.~~

(B) ~~Employees not responsible for staffing essential OKDHS functions.~~ All other employees not specifically identified in (a)(1)(A)(i) through (iv) of this Section or designated to report for duty by their division director are encouraged to report to work if possible. Employees are approved for automatically excused absences when an official announcement has

~~been made to reduce OKDHS services due to hazardous weather conditions.~~

(2) ~~Reduction of services in the Oklahoma City metropolitan area.~~ Decisions concerning reduction of services due to hazardous weather conditions in the seven-county Oklahoma City metropolitan area, Canadian, Cleveland, Lincoln, Logan, McClain, Oklahoma, and Pottawatomie counties, are announced by OPM.

(3) ~~Late arrivals to work or early departures from work.~~ Due to hazardous weather conditions, the Secretary of Safety and Security may authorize the delayed arrival to work or the early departure of employees from work.

(b) Temporary office closings due to imminent peril or other unsafe working conditions.

(1) ~~Offices closed due to imminent peril.~~ If an An OKDHS office ~~must~~ may be temporarily closed because of an imminent peril threatening the public health, safety, or welfare of employees, or the public, OKDHS employees scheduled to work in the closed area may be either placed on paid administrative leave or assigned to work in another location.

(2) ~~Institutions and residential care facilities closed due to imminent peril.~~ If ~~all~~ All or a portion of an OKDHS institution or residential care facility ~~must~~ may be closed because of an imminent peril threatening the health, safety, or welfare of residents, ~~clients, employees, or the public,~~ residents Residents or clients are relocated to other institutions or facilities as appropriate.

(3) ~~Applicable policies upon reopening of closed location.~~ Paid administrative leave is accorded affected employees only when a state office is closed in accordance with OAC 530:10-15-70 and this policy. Upon the reopening of a closed office, institution, or residential care facility, normal OKDHS policies governing leave and OKDHS procedures apply.

[OAR Docket #10-457; filed 3-31-10]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 5. ADULT PROTECTIVE SERVICES

[OAR Docket #10-458]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:

- Subchapter 1. General Provisions
- 340:5-1-1 through 340:5-1-6 [AMENDED]
- 340:5-1-8 [AMENDED]
- Subchapter 3. Reports of Maltreatment of Vulnerable Adults
- 340:5-3-1 [AMENDED]
- 340:5-3-5 through 340:5-3-6 [AMENDED]
- Subchapter 5. Investigation of Adult Protective Services Referrals
- 340:5-5-2 through 340:5-5-7 [AMENDED]
- 340:5-5-8 [NEW]

(Reference APA WF 09-24)

AUTHORITY:

Commission for Human Services, Article XXV, Sections 2 and 4 of the Oklahoma Constitution; Sections 10-101 through 10-111 of Title 43A of

the Oklahoma Statutes; and Sections 40.5 through 40.7 of Title 22 of the Oklahoma Statutes.

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n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

Chapter 5 proposed permanent rule amendments: (1) add law enforcement agencies to the list of persons who may review or receive information from the case record; (2) add clarification of when information may be excluded from disclosure; (3) add new definitions and amend existing definitions; (4) require Oklahoma Department of Human Services (OKDHS) staff to immediately submit all reports of abuse, neglect, or exploitation for screening; (5) clarify that the Oklahoma Department of Mental Health and Substance Abuse Services treats seriously mentally ill and substance abusers when voluntarily requested and the Adult Protective Services (APS) specialist's role when reports are received for this population; (6) clarify the timeframe for screening new reports to identify emergency situations, ensure correct assignment of the report, and facilitate the timely initiation of the investigation; (7) add findings to the elements of an investigation; (8) include information regarding the vulnerable adult's right to religious beliefs for healing; (9) add language regarding a do not resuscitate (DNR) order; (10) add information regarding restricted visitation with a vulnerable adult; (11) add information about when the APS specialist can request the court to order a psychological or psychiatric evaluation; (12) correct a policy cite; (13) add a new rule to provide direction for case destruction; (14) add language about when involuntary court orders are dismissed; (15) add other clarifying information; and (16) update language to current terminology.

CONTACT PERSON:

Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

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 JUNE 1, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

340:5-1-1. Program goals

The Adult Protective Services program (APS) is for vulnerable adults who are reported to be unable to care for themselves and their needs and are reported to be suffering from abuse, neglect, self-neglect, exploitation, or verbal abuse. A protective services investigation is initiated when a ~~referral~~

report is received and assigned. Whenever possible, protective service plans are developed with the knowledge and approval of the adult victim. When it is determined that provision of services without consent is necessary to protect the life and well-being of an adult, such action is taken only with careful consideration of the effect on the adult's sense of autonomy. The goals of the APS program are to:

- (1) reestablish and maintain a stable level of functioning approaching the maximum potential of the vulnerable adult victim of abuse, neglect, self-neglect, financial exploitation, financial neglect, sexual exploitation, abandonment, or verbal abuse;
- (2) reestablish and maintain the vulnerable adult's family and community relationships;
- (3) assist the vulnerable adult to remain in the community as long as possible;
- (4) ensure that the adult who lacks the capacity to consent receives involuntary services that are ordered by the court; and
- (5) assist the adult in obtaining appropriate institutional care if no less restrictive services are available.

340:5-1-2. Principles of APS

(a) The vulnerable adult alleged to need protective services is the client of the Oklahoma Department of Human Services. While outcomes desired by the person who reported the situation, family members, or other caretakers of the ~~client will be vulnerable adult~~ are considered during the investigative process, the focus of Adult Protective Services (APS) intervention is the ~~client-vulnerable adult~~.

(b) The right to self-determination is primary to APS. ~~Intervention is approached~~ The APS specialist approaches intervention with sensitivity to the adult's perception of his or her situation and wishes. ~~An~~ and makes an objective assessment of the circumstances and need for continued involvement ~~is made by the APS specialist.~~

(c) Service planning focuses on services which meet the needs of the vulnerable adult in the least intrusive and least restrictive manner.

340:5-1-3. Program coordination

Family Support Services Division, Adult Protective Services (APS) Unit, has responsibility for program planning, staff training, technical assistance, quality assurance, and policy development. Field Operations Division, area APS program field liaisons representatives (PFR)s, assist in this process by providing local support for APS staff. The APS program is implemented in the field through APS specialists in local Oklahoma Department of Human Services offices.

340:5-1-4. Ethical considerations

The Adult Protective Services (APS) specialist has ethical responsibilities according to Section 10-109a of Title 43A of the Oklahoma Statutes (43A O.S. § 10-109a). The APS specialist maintains professional objectivity when providing or arranging services for vulnerable adults, whether services are paid for by the vulnerable adult or from private or public funds.

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- (1) The APS specialist must not:
 - (A) handle the client's vulnerable adult's personal resources, such as bank accounts, cash, checks, notes, mortgages, trusts, deeds, sales contracts, stocks, bonds, certificates, or other liquid assets without prior APS specialist IV approval of the supervisor;
 - (B) obtain or initiate repairs, personal services, and other necessary actions to provide health care, food, or shelter to or on behalf of a vulnerable adult without prior supervisory APS specialist IV approval. Prior Approval may be verbal rather than written approval is not required in emergency situations where immediate action is required to protect the vulnerable adult from imminent harm or significant loss of property, ~~but all~~ All plans of this nature, along with approval, must be documented in writing in the case record as soon as possible after approval;
 - (C) solicit, charge, request, or accept a fee, gift, reward, or payment of any kind from individuals or staff for services rendered as a volunteer, intern, or employee;
 - (D) use contact with the client vulnerable adult or any member of the client's vulnerable adult's support system for personal gain or personal relationships;
 - (E) after termination of any assignment, make personal contact with a former client or any member of the client's support system or use former contact with a client for personal gain;
 - (F) buy items from a client vulnerable adult;
 - (G) engage in any employment or business interest that would constitute a conflict of interest or impair the APS specialist's ability to carry out duties in an impartial manner;
 - (H) give diagnostic medical or legal opinions;
 - (I) refer the client vulnerable adult to just one physician, attorney, counselor, or other professional for services. The client vulnerable adult is presented options whenever possible;
 - (J) have sexual contact with clients vulnerable adults, their relatives, next of kin, or members of their support system; and
 - (K) make after hours home visits, other than those specifically approved by the ~~supervisor~~ APS specialist IV.
- (2) The APS specialist contacts the ~~supervisor~~ APS specialist IV immediately when the client vulnerable adult or the APS specialist is threatened or injured in the course of the investigation.

340:5-1-5. Confidentiality

- (a) All records, working papers, and reports related to an Adult Protective Services (APS) investigation are confidential under Section 10-110 of Title 43A of the Oklahoma Statutes, (43A O.S. § 10-110) and may be disclosed only by order of the court except under the circumstances described in (b) through (e) of this Section. Representatives of the general public, news media, or agencies not meeting one of the exceptions in (c)

of this Section who request details on a specific case may be referred to the county director, area director, Family Support Services Division (FSSD), APS Unit staff, or the Oklahoma Department of Human Services (OKDHS) Office of Communications for a detailed explanation of OKDHS confidentiality rules.

- (b) When consulting persons knowledgeable of the circumstances of an alleged victim of abuse, neglect, or exploitation, or when making other contacts as part of the investigation or service planning process, the APS specialist may disclose information necessary to ensure that the client vulnerable adult is protected and the client's vulnerable adult's needs are met.

- (c) Certain persons acting in an official capacity with regard to the APS client vulnerable adult may review or receive information from the entire case record, including:

- (1) a district attorney or employees of the district attorney's office;
- (2) the attorney representing the person who is the subject of an involuntary services action;
- (3) the attorney for the Oklahoma Disability Law Center, when involved in representing ~~an APS client~~ the vulnerable adult;
- (4) staff of:
 - (A) an Oklahoma law enforcement agency; ~~or~~
 - (B) a law enforcement agency of another state; ~~including~~
 - (C) a state or local Medical Examiner's Office;
 - (D) a law enforcement agency of a federally recognized tribe in Oklahoma; or
 - (E) a federal law enforcement agency;
- (5) staff of another state's APS program;
- (6) physical or mental health care professionals involved in the evaluation or treatment of the vulnerable adult; and
- (7) OKDHS staff who use the information in carrying out their own responsibilities.

- (d) Any agency or person authorized by OKDHS to provide services to a vulnerable adult ~~client~~ may receive a summary of information necessary to secure or provide appropriate care for the client vulnerable adult.

- (e) The client's vulnerable adult's caretaker, legal guardian, and next of kin may receive summaries of information from an APS case record.

- (f) Some information from APS records may be released to employees or contractors of the State for research purposes, upon application to and approval by the FSSD APS Unit. While local OKDHS offices may release statistical information, no specific case information is released for research purposes unless approval is received from the FSSD APS Unit.

- (g) If federal law specifically prohibits the disclosure of any of the information required by this subsection, that information may be excluded from the disclosed health information.

340:5-1-6. Definitions

The following words and terms, when used in this Subchapter shall have the following meaning, unless the context clearly indicates otherwise.

"Abandonment" means the withdrawal of support or the act of deserting a vulnerable adult by a caretaker or other person responsible for the vulnerable adult's care.

"Abuse" means causing or permitting the:

(A) infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish; or

(B) deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult.

"Activities of daily living (ADLs)" means basic self-care activities such as toileting, transfer, feeding, bathing, and dressing.

"Adult" means a person 18 years of age or older.

"Alleged victim" means a vulnerable adult who is suspected of being a victim of maltreatment.

"APS specialist" means an Oklahoma Department of Human Services (OKDHS) worker who has successfully completed Adult Protective Services (APS) New Worker Academy or is working under the oversight of a more experienced APS specialist.

"APS specialist III" means the lead APS specialist who mentors and may be designated to act for the APS specialist IV.

"APS specialist IV" means any OKDHS staff assigned or designated to act in an APS supervisory capacity.

"Caretaker" means a person who is responsible for the care of or financial management for a vulnerable adult as a result of family relationship or has assumed responsibility for care of a vulnerable adult voluntarily, by contract, or by friendship; or who serves as a legally appointed guardian, limited guardian, or conservator.

"Emergency" means a situation in which a vulnerable adult is likely to suffer death or serious physical harm without immediate intervention.

"Evidence" means all documentation, photographs, interviews, observations, objects, and other information collected, observed, or otherwise obtained during the course of an investigation.

"Executive function" means the brain's ability to absorb information, interpret this information, and make decisions based upon this information.

"Exploitation" means unjust or improper use of the person or resources of a vulnerable adult for the profit or advantage of another person through undue influence, coercion, harassment, duress, deception, false representation, or false pretense.

"Financial neglect" means repeated instances by a caretaker or other person who has assumed the role of financial management of failure to use the resources available to restore or maintain the health and physical well-being of a vulnerable adult, including but not limited to:

(A) squandering or negligently mismanaging the money, property, or accounts of a vulnerable adult;

(B) refusing to pay for necessities or utilities in a timely manner; or

(C) providing substandard care to a vulnerable adult despite the availability of adequate financial resources.

"Guardian" means one of the types of guardianship specified in the Oklahoma Guardianship and Conservatorship Act, Title 30 of the Oklahoma Statutes.

(A) **General guardian.** A general guardian is a person appointed by the court to serve as the guardian of an incapacitated person to ensure that the essential requirements for the health and safety of the person are met, to manage the estate of the person, or both.

(B) **Limited guardian.** A limited guardian is a person appointed by the court to serve as the guardian of a partially incapacitated person and is authorized by the court to exercise only certain powers of a guardian over the person, or estate or financial resources of the person, or both.

(C) **Special guardian.** A special guardian is a person appointed by the court to exercise certain specified powers to alleviate a situation in which there is a threat of serious impairment to the health or safety of an incapacitated or partially incapacitated person, or a situation in which the financial resources of the person will be seriously damaged or dissipated unless immediate action is taken.

"Incapacitated adult" means a vulnerable adult whose ability to receive and evaluate information effectively or to make and to communicate responsible decisions is impaired to such an extent that the person lacks the capacity to manage his or her financial resources or to meet essential requirements for the person's mental or physical health or safety without assistance.

"Indecent exposure" means forcing or requiring a vulnerable adult to:

(A) look upon the body or private parts of another person or upon sexual acts performed in the presence of the vulnerable adult; or

(B) touch or feel the body or private parts of another person.

"Information and Referral (I & R)" means a report that has been screened by the APS specialist IV and does not contain an alleged vulnerable adult and at least one allegation of maltreatment.

"Instrumental activities of daily living (IADLs)" means abilities necessary for an adult to function independently in the community, such as preparing meals, using the telephone, driving or arranging for transportation, shopping, and handling finances.

"Mandatory reporter" means any person who has reasonable cause to believe someone is suffering from abuse, neglect, or exploitation.

"Maltreatment" means abuse, neglect, self-neglect, financial exploitation, sexual exploitation, financial neglect, abandonment, or verbal abuse.

"Neglect" means:

(A) failure to provide protection for a vulnerable adult who is unable to protect his or her own interest;

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- (B) failure to provide adequate shelter, nutrition, health care, or clothing for a vulnerable adult; or
- (C) negligent acts or omissions that result in harm or unreasonable risk of harm to a vulnerable adult through action or inaction, or lack of supervision by a caretaker providing direct services.

"Power of attorney" means authority granted by a legal document authorizing a person or other entity to act for the principal, subject to the extent of the power authorized. The affidavit may be durable. If it is durable, the power of attorney has been filed at the county court house and becomes effective when the principal loses decision making abilities as defined by the document and instructions of the principal. The power is revoked upon:

- (A) written revocation of the principal;
- (B) incapacity of the principal unless it is a durable power of attorney;
- (C) death of the principal;
- (D) a termination date if specified in the document;
- (E) order of the court; or
- (F) the appointment of a guardian, in most cases.

"Referral" means a report that has been screened by the APS specialist IV and assigned for investigation.

"Report" means any allegation of maltreatment that is received by OKDHS that has not yet been screened or assigned for investigation.

"Self-neglect" means neglect brought about by a vulnerable adult's own actions or inactions which causes the vulnerable adult to fail to meet the essential requirements for physical or mental health and safety due to the vulnerable adult's lack of awareness, incompetence, or incapacity.

"Services which are necessary to aid an individual to meet essential requirements for mental or physical health and safety" means services which include, but are not limited to the:

- (A) identification of adults in need of protective services;
- (B) provision of medical care for physical or mental health needs; and
- (C) provision of assistance in personal hygiene, food, clothing, adequately heated and ventilated shelter, protection from health and safety hazards, protection from physical maltreatment, guardianship referral, outreach, and transportation necessary to secure any of such needs. This excludes taking the adult into physical custody without the adult's consent except through proper procedures for the provision of involuntary services.

"Sexual abuse" means:

- (A) oral, anal, or vaginal penetration of a vulnerable adult by or through the union with the sexual organ of a caretaker or other person providing services to the vulnerable adult, or the anal or vaginal penetration of a vulnerable adult with any other object by a caretaker or other person providing services to the vulnerable adult;

- (B) for the purpose of sexual gratification, the touching, feeling, or observation of the body or private parts of a vulnerable adult by a caretaker or other person providing services to the vulnerable adult; or
- (C) indecent exposure by a caretaker or other person providing services to the vulnerable adult.

"Sexual exploitation" means and includes, but is not limited to, a caretaker causing, allowing, permitting, or encouraging a vulnerable adult to engage in prostitution or in lewd, obscene, or pornographic photographing, filming, or depiction of the vulnerable adult as those acts are defined by Oklahoma law.

"Substantiated" means the greater weight of the evidence collected during an APS investigation determines that maltreatment occurred and the alleged victim meets the definition of a vulnerable adult.

"Temporary guardian" means a person or other entity appointed by the court under Title 43A of the Oklahoma Statutes with authority only to consent on behalf of an incapacitated adult to the provision of protective services determined necessary to remove conditions creating an emergency need and other services approved by the court. A temporary guardian serves in that capacity only until the expiration of the order appointing him or her.

"Undue influence" means the substitution of one person's will for the true desires of another.

"Unsubstantiated" means evidence found during an APS investigation was insufficient to determine maltreatment occurred.

"Verbal abuse" means the use of words, sounds, or other communication including, but not limited to, gestures, actions, or behaviors, by a caretaker or other person providing services to a vulnerable adult that are likely to cause a reasonable person to experience humiliation, intimidation, fear, shame, or degradation.

"Vulnerable adult" means an adult who, because of physical or mental disability or other impairment, may be subject to maltreatment and is substantially impaired in his or her ability to independently:

- (A) provide adequately for his or her own care or custody;
- (B) manage his or her property and financial affairs effectively;
- (C) meet essential requirements for mental or physical health or safety; or
- (D) protect himself or herself from maltreatment without assistance. This determination is not made based on a person's eligibility for disability benefits from any source or on the impairment being permanent, but solely on the adult's reported physical or mental condition at the time an APS referral report is made and the APS specialist's assessment of that condition during investigation.

340:5-1-8. Complaints concerning the APS program

Complaints regarding an investigation or the provision of services may be submitted to the Oklahoma Department of

Human Services (OKDHS) by telephone or in written form, including e-mail. Complaints regarding:

- (1) Adult Protective Services (APS) policy and procedure are referred to the county director who performs a case review. A The county director sends a written response is provided to the complainant within 45 calendar days stating the general findings of the review. If not satisfied with the county director's findings, the complainant may, within 30 days of the date of the letter, submit a written appeal to the, OKDHS Family Support Services Division, APS Unit, P. O. Box 25352, Oklahoma City, OK 73125. A committee composed of Family Support Services Division and Field Operations Division staff reviews the appeal and sends the complainant its decision within 30 calendar days;
- (2) possible inappropriate treatment by an APS specialist or supervisor APS specialist IV are referred to the appropriate county director for appropriate action; and
- (3) involuntary services are handled through the appropriate judicial system.

SUBCHAPTER 3. REPORTS OF MALTREATMENT OF VULNERABLE ADULTS

340:5-3-1. Reporting a need for protective services

(a) **Mandatory requirement to report.** Any person having reasonable cause to believe that a vulnerable adult is suffering from abuse, neglect, or exploitation is mandated by law, ~~{Section 10-104-A~~ 10-104(A) of Title 43A of Oklahoma Statutes ~~(43A O.S. § 10-104(A))~~, to make a report to the Oklahoma Department of Human Services (OKDHS), the office of the district attorney in the county in which the suspected incident occurred, or local law enforcement.

- (1) State law provides that any person who knowingly and willfully fails to promptly report any abuse, neglect, or exploitation is, upon conviction, guilty of a misdemeanor.
- (2) Any person who willfully or recklessly makes a false report or a report without a reasonable basis is liable in a civil suit for any actual damages suffered by any person named in the report and any punitive damages set by the court or jury.
- (3) Any person exercising good faith and due care in making a report of alleged abuse, neglect, or exploitation has immunity from any civil or criminal liability that might otherwise be incurred.
- (4) Every person in Oklahoma is a mandatory reporter, and select groups who routinely have contact with vulnerable adults are specifically named in Oklahoma statutes, including:
 - (A) social workers;
 - (B) physicians;
 - (C) operators of emergency response vehicles;
 - (D) mental health professionals;
 - (E) law enforcement;
 - (F) staff of domestic violence programs;

(G) long-term care facility personnel including staff of:

- (i) nursing facilities;
 - (ii) intermediate care facilities for persons with mental retardation;
 - (iii) assisted living facilities;
 - (iv) residential care facilities; and
 - (v) Oklahoma veteran's centers;
- (H) persons entering into transactions with a caretaker or other person who has assumed the role of financial management for a vulnerable adult;
- (I) staff of:
- (i) residential care facilities;
 - (ii) group homes; and
 - (iii) employment settings for individuals with developmental disabilities;
- (J) job coaches;
- (K) community service workers;
- (L) personal care assistants; and
- (M) other medical professionals.

(b) **Content of the report.** The law requires that the report of alleged abuse, neglect, or exploitation of vulnerable adults include the information in (1) through (3) of this subsection. The minimum information required by law is:

- (1) the name, address, or location of the vulnerable adult;
- (2) the name or address of the caretaker, if any; and
- (3) a description of the situation of the vulnerable adult.

(c) **Obtaining the name of the reporter.** Although the person making the report is not required by law to provide a name, address, or telephone number, such information is helpful in the event the APS specialist has further questions or needs to clarify any points of the complaint.

(d) Submission of reports for screening. OKDHS staff immediately submits all reports for screening by entering information into the APS Computer System or notifying local APS staff.

340:5-3-5. Multiple jurisdictions

Some reports which are appropriate for Adult Protective Services (APS) intervention are also required to be sent to other agencies.

(1) **Reports which are sent to Oklahoma State Department of Health (OSDH).** Reports alleging maltreatment of vulnerable adults are accepted and screened by APS but are also sent to OSDH, Protective Health Services, for residents of:

- (A) residential care facilities;
- (B) assisted living facilities; and
- (C) nursing facilities when the report is of self-neglect or maltreatment by a person not employed by the facility.

(2) **Reports which are sent to law enforcement.** Reports alleging illegal activity or situations which may be dangerous for an APS specialist are referred to local law enforcement. A referral report of this type does not relieve APS of responsibility for assessing the need for protective services in such situations.

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(3) **Reports involving substance abusers and persons with a mental illness.** Reports regarding alleged substance abusers or persons with a mental illness are submitted to an APS supervisor for screening and may be appropriate for APS investigation. If upon investigation the APS specialist finds that the client's primary problem is that of substance abuse or dependency, or that the client is in need of mental health treatment, the APS specialist assists the client in obtaining appropriate mental health treatment. The APS specialist may assist law enforcement officers when requested by providing behavioral assessments necessary to obtain involuntary mental health treatment, such as third party affidavits. Oklahoma law gives the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) primary responsibility for the mentally ill and substance abusers. ODMHSAS actively treats seriously mentally ill persons until their condition is stabilized on a voluntary basis. Community mental health centers administered by or under contract to ODMHSAS provide recommended aftercare services to patients who are discharged from state mental hospitals and voluntarily request and accept mental health services.

(A) The APS specialist may assist law enforcement officers when requested by providing behavioral assessments necessary to obtain involuntary mental health treatment, such as third party affidavits.

(B) When reports are received regarding persons who are alleged to have a mental illness or a substance abuse problem, they are screened by the APS specialist IV to determine whether it is appropriate for APS investigation.

(C) If, after investigation, the vulnerable adult's primary problem is determined to be substance abuse dependency or mental illness, the APS specialist directs the vulnerable adult to the nearest ODMHSAS contract facility for outpatient service. The APS specialist calls law enforcement for securing emergency detention if the person is a danger to self or others.

340:5-3-6. Screening APS reports

(a) **Time frame for screening Adult Protective Services (APS) reports.** APS specialist IVs are responsible for screening new reports on the APS Computer System on a regular basis throughout the day to identify emergency situations and to ensure assignment to the correct human services center (HSC).

(ab) **Responsibility for screening reports.** Adult Protective Services (APS) supervisors specialist IVs are responsible for screening reports and either accepting them as APS referrals or classifying them as Information and Referral. When a request is accepted as an APS referral, the supervisor APS specialist IV determines whether an emergency response is indicated, whether the referral is employee related, and which APS specialist is assigned the referral. APS specialist IVs complete screening in a manner to facilitate the timely initiation of the investigation as defined in OAC 340:5-5-2.

(bc) **Reports involving domestic violence.** APS situations are often forms of domestic violence. Reports received alleging maltreatment of an adult by a spouse or other family or household member are member are considered protective services requests if the alleged victim is vulnerable as defined in OAC 340:5-1-6.

(ed) **Reports involving OKDHS employees or their families.** Specific procedures are followed when a report of maltreatment is received which involves an employee of the Oklahoma Department of Human Services (OKDHS).

SUBCHAPTER 5. INVESTIGATION OF ADULT PROTECTIVE SERVICES REFERRALS

340:5-5-2. Initiating investigations

An Adult Protective Services (APS) specialist initiates an investigation ~~is initiated~~ by a visit to the vulnerable adult who is the alleged victim (AV) at the adult's home or other place of residence.

(1) Time frame for initiating investigations.

(A) ~~Investigations~~ The APS specialist initiates the investigation of referrals of maltreatment ~~are initiated~~ as soon as possible within three working days, not to exceed 72 hours from the time of the receipt of the report in the Oklahoma Department of Human Services (OKDHS), excluding weekends and official OKDHS holidays.

(B) In the case of an emergency situation when immediate action may be required, the APS specialist ~~initiates the investigation is initiated~~ as soon as possible within four hours of receipt.

(2) **Denial of access to the AV.** If the APS specialist is denied entry into the residence of the AV, or is denied a private interview with the AV, OKDHS staff may petition the court for an order allowing entry or access.

340:5-5-3. Elements of an investigation

Although the investigation process may vary depending on the initial allegations and other factors, all Adult Protective Services (APS) investigations include paragraphs (1) through (10).

(1) **Notification of local law enforcement.** Local law enforcement is provided notification of all APS referrals assigned for investigation.

(2) **Efforts to locate and notify others.** APS specialists must make every reasonable effort to locate and notify the ~~vulnerable adult's~~ alleged victim's (AV's) caretaker, guardian, and next of kin.

(3) **Visits to and interviews with the vulnerable adult.** ~~Each~~ As mandated by Section 10-105(C)(1)(a) of Title 43A of the Oklahoma Statutes (43A O.S. § 10-105(C)(1)(a)) each APS investigation includes at least one visit and private interview with the vulnerable adult, and may include as many as are necessary to reach a conclusion and determine what, if any, protective services are needed.

(4) **Consultation with others.** ~~Other~~ The APS specialist interviews other people who have or can reasonably be expected to have pertinent knowledge about the ~~alleged victim's (AV's) circumstances~~ are interviewed during the investigation, including any alleged perpetrator (AP) of maltreatment.

(A) ~~This consultation~~ Consultation includes medical, psychiatric, or other evaluations as necessary to assist in the determination of a vulnerable adult's decision-making capacity and need for services.

(B) The AV's permission is not required for these contacts.

(5) **Photographs.** The APS specialist may take still photographs or video recordings to document injuries to the vulnerable adult, or conditions in the adult's residential environment which have resulted or may result in an injury or serious harm to the adult.

(6) **Other relevant data.** The APS specialist collects any data relevant to the situation being investigated; including records, to arrive at a finding on the referral. If the APS specialist is denied access to pertinent records, documentation, or other information relevant to the investigation, the Oklahoma Department of Human Services (OKDHS) may petition the court for an order allowing access.

(7) **Determining the adult's decision-making capacity.** OKDHS is mandated by ~~Section 10-106.C of Title 43A of the Oklahoma Statutes~~ 43A O.S. § 10-106(C) to determine a vulnerable adult's risk and needs along with the client's vulnerable adult's capacity to consent to receive services, especially with regard to the need for involuntary services. Each investigation includes an evaluation of the vulnerable adult's decision-making capacity.

(A) Information is obtained from medical or psychiatric sources, if available, to assist in the determination. In making this determination, the APS specialist assesses and considers:

- (i) the client's vulnerable adult's short and long term memory;
- (ii) the client's vulnerable adult's executive functioning by their ability to plan and execute a plan;
- (iii) the client's vulnerable adult's ability to recognize risk factors;
- (iv) denial of problems by ~~client~~ the vulnerable adult or caretaker;
- (v) the client's vulnerable adult's executive functioning by ~~their~~ his or her ability to understand and follow directions;
- (vi) indicators of affective disorders such as depression or bipolar disorder; and
- (vii) indicators of substance abuse, dementia, delirium, psychosis, traumatic brain injury, uncharacteristic socially inappropriate behaviors, impaired decision-making, and other factors.

(B) The APS specialist's assessment of a client's vulnerable adult's mental capacity to consent to

protective services takes into account the client's vulnerable adult's awareness of:

- (i) the limitations and deficiencies in the physical environment;
- (ii) the client's vulnerable adult's own physical or mental limitations;
- (iii) resources available to assist in meeting the client's vulnerable adult's needs; and
- (iv) the consequences to the client vulnerable adult if nothing is done to improve the situation.

(C) If a client vulnerable adult is deficient in all or most of the areas in (B) of this paragraph, he or she may lack the capacity to consent to protective services and it may be appropriate to petition the district court for an order authorizing the provision of needed services.

(D) If a client vulnerable adult expresses awareness of all four areas in (B) of this paragraph, it is likely that the present circumstances are the client's vulnerable adult's choice, though in some cases a client vulnerable adult might express awareness in these areas and still lack the capacity to consent to provision of services.

(E) If a client vulnerable adult appears unaware of the consequences of the present situation, and an emergency exists, legal intervention is appropriate.

(8) **Evaluation to determine the need for protective services.** The evaluation consists of the APS specialist's analysis and consultation with the ~~supervisor~~ APS specialist IV of all evidence gathered during the initial phases of the investigation. The evaluation includes consideration of whether:

- (A) the vulnerable adult needs protective services. If so, the need for protective services is documented ~~in a statement that includes~~ to include the least restrictive services that will meet the person's needs;
- (B) services that are identified as needed are available through OKDHS or in the community, and the sources and manner in which they can be provided. Options are explored with the vulnerable adult;
- (C) the vulnerable adult is capable and willing to obtain services for himself or herself;
- (D) the vulnerable adult can pay for needed services or is eligible for public assistance programs;
- (E) a caretaker or guardian is willing to provide or agree to the provision of needed services; and
- (F) the vulnerable adult desires the services.

(9) **Completion of investigative report.** From the date an APS referral is received, the APS specialist completes the investigative report within 30 calendar days for self neglect referrals and 60 calendar days for referrals involving an ~~alleged perpetrator AP~~. The APS ~~supervisor~~ specialist IV may extend the time frame for completion of an investigation for an additional 30 calendar day period when it is in the client's vulnerable adult's best interest to do so. To complete the investigation, the APS specialist:

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- (A) completes necessary interviews and assessments including identification of any immediate service needs;
- (B) completes all final documentation;
- (C) submits a report to the local district attorney; and
- (D) makes a determination of substantiated or unsubstantiated based on the definitions of terms in OAC 340:5-1-6.

(10) **Findings.** The APS specialist, in conjunction with the APS specialist IV, makes a final determination of the investigative process on each allegation contained in the APS referral. Each allegation is determined to be substantiated or unsubstantiated and the investigation documented in accordance with OAC 340:5-5-5. The APS specialist IV notifies the appropriate area director immediately of substantiated referrals in which an OKDHS employee is named as perpetrator.

(11) **Follow-up.** The APS specialist, in consultation with the APS ~~supervisor~~ specialist IV, is responsible for determining what follow-up is needed in each case investigated.

(A) On cases not requiring court-ordered involuntary services, follow-up needs are determined on a case-by-case basis.

(B) For referrals that resulted in a client vulnerable adult receiving involuntary services, OKDHS is responsible for ensuring basic needs for safety and security are met as required by the court. The APS specialist monitors the delivery of court-ordered protective services and continues to assess the need for additional services determined by the changing needs of the client vulnerable adult. At least one follow-up visit is made at 30 days regardless of whether OKDHS continues to hold temporary guardianship.

(i) If the client's vulnerable adult's situation is stable or improving after 30 days and OKDHS no longer holds guardianship, the case is closed.

(ii) If OKDHS continues to hold guardianship after 30 days, a follow-up visit to the client vulnerable adult is required at least once each 30 days for the duration of the temporary guardianship.

(iii) If the client's vulnerable adult's situation is deteriorating at any time during the follow-up period, the service plan is reassessed and changed as needed with the concurrence of the court.

(iv) Follow-up visits to clients vulnerable adults receiving involuntary services are made at least every 30 days, but may be made as often as needed to comply with APS specialist guardianship responsibilities and to monitor the client's vulnerable adult's situation.

(v) If an out-of-home placement is used as a temporary or long term solution to identified needs, the APS specialist has regular contact with the client-vulnerable adult for the duration of the court ordered temporary guardianship. The frequency of this contact is determined by the APS

specialist and ~~supervisor's~~ APS specialist IV's determination of the specific client situation and the availability of an independent objective third party to provide follow-up and notification to the APS specialist. ~~Visits to~~ The APS specialist visits the client ~~are made~~ vulnerable adult at least once every 30 calendar days while the client vulnerable adult is under APS guardianship. ~~Information~~ The APS specialist documents information from follow-up visits ~~is documented in the APS Computer System and made~~ makes it available to the court on review of the guardianship. Follow-up visits may be made as frequently as the APS specialist and ~~supervisor~~ specialist IV determine they are needed, based on an individual client's vulnerable adult's situation. For clients-vulnerable adults placed:

(I) in medical facilities such as geriatric psychiatric units or medical hospital for care, the worker follows-up with the client's vulnerable adult's assigned social worker;

(II) in group homes, residential care facilities, and assisted living centers, the APS specialist may contact other professionals not associated with the facility who provide treatment or services to the client vulnerable adult for follow-up information every 30 calendar days or more often as indicated;

(III) at any facility owned or operated by OKDHS, ~~face-to-face visits are made~~ the APS specialist makes face-to-face visits every 30 calendar days with interim contacts with the social work staff or more often as indicated; and

(IV) at any type of nursing home, the APS specialist visits the client-vulnerable adult, at least once every two weeks during the first month of placement to check for changes in the client's vulnerable adult's condition, such as injuries, signs of over-medication, and cognitive state. ~~Concerns are discussed~~ The APS specialist discusses concerns with the nursing home administrator or director of nursing, and the APS ~~supervisor~~ specialist IV. After the first month, the APS specialist visits the client vulnerable adult at least once every 30 calendar days, reviews the nursing home charts and incident reports, and discusses care needs with the staff and client's vulnerable adult's family, if available.

(C) The APS specialist may determine as a result of follow-up contacts that further placement options need exploring. This may be the result of inappropriate action on the part of the provider, current information about the facility's ability to provide care for the client vulnerable adult, or the facility's request to relocate the client vulnerable adult.

(i) Placement alternatives are determined in accordance with this Section and approved by the ~~supervisor~~ specialist IV, county director, and

the area APS program field liaison representative (PFR).

(ii) The court appointed attorney for the client vulnerable adult and the family is notified of the problems and alternatives that have been developed.

(iii) ~~A The APS specialist submits~~ a written report of the change of placement ~~is submitted~~ to the court, with a copy of the motion to the client's vulnerable adult's family and attorney of record.

(D) ~~Follow-up The APS specialist makes frequent contact with clients vulnerable adults remaining at home in temporary guardianship is made frequently with~~ at a minimum of every 30 calendar days to assure that client the vulnerable adult's safety and needs are being met by the established service plan. The APS specialist:

(i) ~~Modifications are made~~ makes modifications as needed to the service plan as well as provision of services by providers;

(ii) ~~The evaluates the~~ quality of care and the method of contact ~~are evaluated~~ on a case-by-case basis depending on the individual needs of the specific client vulnerable adult including a face-to-face visit every 30 calendar days; and

(iii) ~~Reports are submitted~~ submits reports at the request of the court or a minimum of every 30 calendar days.

(E) In the event the client vulnerable adult is placed in a facility out-of-county, the APS ~~supervisor or designee specialist IV~~ immediately contacts the APS ~~supervisor specialist IV~~ in the county of placement to notify the receiving county of the placement and that follow-up activities pursuant to this paragraph must be provided by the receiving county.

(i) The APS specialist in the county where the client vulnerable adult is residing is the worker designated to provide follow-up services for temporary guardianship cases.

(ii) The resident county APS specialist is responsible for all issues that require written consent and other problems or concerns and acts in coordination with the APS specialist in the county of court jurisdiction for reporting to the court as required by the court order with a minimum of every 30 calendar days.

(iii) The APS specialists and ~~supervisors specialist IVs~~ from both counties discuss and determine the best course of action for renewals of temporary guardianships.

(I) The decision takes into account the client's vulnerable adult's specific situation, the family and their desires, the availability of the courts in the two counties, and the advice of the client's vulnerable adult's court appointed attorney, and the attorney(s) representing OKDHS in the matter.

(II) The area APS ~~field liaison PFR, Family Support Services Division (FSSD)~~ APS Unit, and attorneys for the OKDHS ~~Legal Division~~ Office of General Counsel are consulted as needed for assistance in determining the best course of action.

340:5-5-4. Special considerations during investigations

(a) **Referrals regarding members of Indian tribes.** Referrals are accepted for an alleged victim (AV) who is a tribal member according to the Protective Services for Vulnerable Adults Act as set forth in Sections 10-101 through 10-110 of Title 43A of the Oklahoma Statutes (43A O.S. § 10-101 through 10-111). The Adult Protective Services (APS) specialist provides or arranges voluntary or involuntary services as indicated for a vulnerable adult regardless of whether the adult resides on tribal land.

(b) **Referrals involving two or more counties.** If a referral involves two or more counties, as when the AV lives in one county and the alleged perpetrator (AP) in another or when the AV moves either temporarily or permanently to another county before the investigation has been completed, local APS staff from both human services centers (HSCs) are involved in the investigation.

(c) **Referrals involving Soonercare (Medicaid) fraud.** When an APS investigation indicates fraud by a provider receiving Medicaid funds, APS staff immediately notifies the Medicaid Fraud Control Unit (MFCU) in the Office of the Oklahoma Attorney General. APS cooperates with any investigation by MFCU. If MFCU declines to investigate, APS staff completes the investigation and sends a summary report to MFCU upon completion of the investigation.

(d) **Referrals involving persons and provider agency employees.** APS investigations of maltreatment of vulnerable adults may include all persons in a relationship of caretaker, regardless of organizational affiliation, except those noted in Subchapter 3 of this Chapter. Care providers who may be subject to APS investigation include, but are not limited to, home health providers, community services workers for persons with developmental disabilities, personal care assistants, adult foster homes, adult day care centers, independent living centers, residential care facilities, and assisted living centers.

(1) These agency investigations include all the elements of an APS investigation, with special emphasis placed on:

- (A) interviewing agency staff and other residents or participants who may have knowledge of the reported incident;
- (B) obtaining copies of applicable charts and records;
- (C) reviewing medication lists and schedules;
- (D) taking photographs;
- (E) examining habilitation or other care plans;
- (F) examining financial records and other money management documentation;
- (G) reviewing time schedules and time sheets; and

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- (H) requesting any other information needed to complete the investigation.
- (2) If assistance is needed in assessing medical issues in these cases, involvement of the OKDHS long-term care nurse may be requested.
- (3) APS staff submits findings of substantiated referrals of maltreatment by persons who are personal care assistants, Medicaid personal care attendants (MPCA), and community services workers subject to the requirements of the Community Services Worker (CSW) Registry maintained by Developmental Disabilities Services Division (DDSD) pursuant to ~~Section 1025.3 of Title 56~~ 56 O.S. § 1025.3 of the Oklahoma Statutes within three working days to the OKDHS Office of Client Advocacy for consideration of placement of the worker's name on the statewide CSW Registry. Persons whose names are on the CSW Registry must not be employed by providers for direct care services to persons with developmental disabilities or as personal care attendants (PCA) paid through the Medicaid ADvantage Waiver.
- (4) For provider agency employees who are not subject to the CSW Registry requirements, such as program coordinators, job coaches, bus drivers, or administrative personnel, APS staff notifies the agency director or board ~~is notified~~ of any substantiated elements of the investigation. Any corrective action plan on the part of the provider agency becomes a part of the APS case record. If the provider agency fails to cooperate in addressing the substantiated elements of the investigation, APS staff notifies the licensing agency, any appropriate governing board, and the district attorney's (DA's) office of the failure to cooperate.
- (e) **Referrals involving other licensed or certified persons.** APS staff sends findings to any state agency with concurrent jurisdiction over persons or issues identified in the investigation, including, where appropriate, the Oklahoma State Department of Health (OSDH), the Oklahoma Board of Nursing, and any other appropriate state licensure or certification board, agency, or registry.
- (f) **Referrals alleging exploitation.** Referrals involving exploitation are complex. To assist in handling some of these referrals, the OKDHS Office of the Inspector General (OIG) may accept for investigation referrals of exploitation involving large amounts of funds or the need to access complex records regarding financial transactions. If OIG declines to investigate, the APS specialist completes the investigation. Protective services that may be provided in cases of exploitation include:
- (1) changing the representative payee;
 - (2) freezing all assets of the ~~client~~ vulnerable adult;
 - (3) petitioning the court for an order allowing access to records;
 - (4) redirecting or stopping the flow of ~~client~~ the vulnerable adult's assets into the alleged ~~perpetrator's~~ perpetrator's accounts; and
 - (5) stopping perpetrator access to the alleged victim's account(s).
- (g) **Persons referred to OKDHS by the courts.** Courts are not authorized to remand criminal defendants to OKDHS based

on a finding of lack of competency. Courts are authorized to refer the alleged incompetent defendant to OKDHS for consideration of voluntary assistance according to ~~Section 1175.6(B) of Title 22 of the Oklahoma Statutes~~ 22 O.S. § 1175.6(b)(B). In order to qualify for such findings, the court must make findings described in (1) or (2) of this subsection.

- (1) Referral for voluntary services occurs when the court finds that the person is incompetent for reasons other than the AV is a person requiring treatment under ~~Title 43A of the Oklahoma Statutes~~ O.S., and is found not to be dangerous.
 - (2) When a court, the DA, or the attorney for a criminal defendant notifies the APS specialist that a referral for voluntary APS services has been made, the APS specialist obtains a copy of the order from the person making the referral. If, after evaluation, it appears to the APS specialist the AV may also be developmentally disabled, the APS specialist immediately contacts the DDSD Area Intake office and requests their involvement in the process of determining what voluntary services are available. This is a joint effort between the APS specialist and the DDSD case manager.
- (h) **AV receiving services from DDSD.** When an AV is receiving or may be eligible for services from DDSD, the APS specialist contacts the appropriate DDSD Area Intake office to coordinate activities to enhance the AV's safety. ~~Section 1175.3(D)(1)(b) of Title 22 of the Oklahoma Statutes~~ 22 O.S. § 1175.3(D)(1)(b) authorizes a court to call for DDSD to conduct a competency evaluation to determine whether mental retardation or other developmental disability may be involved.
- (i) **Referrals involving residents of residential care facilities, assisted living facilities, and continuum of care facilities.** A copy of the final investigative report is sent to OSDH.

340:5-5-5. Documentation of APS cases

The Adult Protective Services (APS) specialist documents the referral, all interviews, record reviews, other evidence, and findings of all investigations in the APS case.

(1) Upon completion of the investigation, the identified caretaker, legal guardian, and next of kin receives a letter from the Oklahoma Department of Human Services (OKDHS) pursuant to Section 10-105.1(C)(6) of Title 43A of the Oklahoma Statutes.

(2) When the vulnerable adult has a court-appointed guardian, the APS specialist notifies the court of jurisdiction of the findings as mandated by 43A O.S. § 10-105.1(C)(6).

340:5-5-6. Provision of protective services to clients vulnerable adults receiving APS services

- (a) **Voluntary protective services.** Protective services may be provided on a voluntary basis when a vulnerable adult consents to provision of services, requests services, and is willing to allow the Adult Protective Services (APS) specialist to provide or arrange for services as authorized by Section 10-106 of Title 43A of the Oklahoma Statutes (43A O.S. § 10-106).

(b) **Payment for protective services.** The cost of providing voluntary or involuntary protective services is borne by the ~~client~~ vulnerable adult if the APS specialist determines that the person is financially able to make payment or by any private or public programs for which the vulnerable adult is eligible. If a caretaker controls the person's funds and refuses to pay for necessary services, this may be construed as caretaker interference and is handled as described in (3) of this subsection.

(1) **Payment for voluntary services.** If voluntary services are required to meet an emergency need and no other payment source is available, ~~the APS specialist follows procedures described in (3) of this subsection are followed.~~ In cases where the services are not to meet an emergency need, the APS specialist arranges for voluntary services if:

- (A) services can be provided free of charge;
- (B) the ~~client~~ vulnerable adult has funds and agrees to pay for the services; or
- (C) there is a public or private assistance program available to pay for the services.

(2) **Payment for involuntary services.** Payment for involuntary protective services is made from the ~~client's~~ vulnerable adult's funds only upon order of the court. If payment is required for involuntary services, procedures described in (3) of this subsection are followed if:

- (A) no funds are available from the ~~client's~~ vulnerable adult's assets; and
- (B) no private or public payment source is available.

(3) **Payment for emergency protective services.** The Oklahoma Department of Human Services (OKDHS) maintains a limited APS Emergency Fund that may be accessed only when specific criteria are met. This fund is used as a short-term measure for crisis situations until other arrangements are made.

(c) **Court-related services.** All petitions or motions filed with the court regarding a vulnerable adult require the signature of the district attorney (DA), assistant district attorney (ADA), or OKDHS ~~Legal Division~~ Office of General Counsel attorney.

(d) **Non-cooperation of caretaker.** When a vulnerable adult consents to receive protective services but the caretaker refuses to allow the provision of services, OKDHS may petition the court for an injunction prohibiting the caretaker from interfering with the provision of protective services in accordance with subsection (e).

(e) **Petitioning the court - order enjoining caretaker.** When the ~~client's~~ vulnerable adult's caretaker refuses to allow the provision of protective services to which the ~~client~~ vulnerable adult has consented or otherwise interferes in the provision of services, OKDHS may petition the court for an Order to Enjoin Caretaker.

(f) **Refusal to consent to protective services.** If a vulnerable adult does not consent to the provision of needed services, or withdraws consent after it is given, the APS specialist documents the ~~client's~~ vulnerable adult's refusal in the case narrative or on Form 08AP002E, Adult Protective Services Report of Investigation. Services are terminated unless OKDHS

determines that the person lacks capacity to consent. In that case, the APS specialist considers action as outlined in OAC 340:5-1-4.

(g) **Religious beliefs.** A vulnerable adult has the right to depend on spiritual means for healing through prayer, in accordance with the practices of a recognized religious method in accordance with the tenets and practices of said church as mandated by 43A O.S. § 10-103(B).

(gh) **Involuntary protective services.** Involuntary protective services are authorized by 43A O.S. § 10-107. If a vulnerable adult is suffering from abuse, neglect, or exploitation that presents a substantial risk of death or immediate and serious physical harm to self, or significant and unexplained depletion of the adult's estate, but lacks the capacity to consent to receive protective services and no consent can be obtained from anyone acting as caretaker, the services may be ordered by the court on an involuntary basis. ~~The~~ In accordance with 43A O.S. § 10-107(B)(1), the court authorizes provision of specific services that the court finds least restrictive of the rights and liberty while consistent with the welfare and safety of the person involved.

(hi) **Petitioning the court - emergency order for involuntary protective services.** OKDHS may petition the court for an order to provide emergency protective services. The petition is made in the county of the ~~client's~~ vulnerable adult's residence or in a county where any of the protective services are provided.

(1) If the court issues an emergency order to provide protective services ~~is issued by the court~~, the order includes the appointment of a temporary guardian for the person in need of services. The temporary guardian may be either OKDHS or an interested person. The order gives the temporary guardian authority only to consent to the specified protective services on behalf of the person.

(2) The vulnerable adult, temporary guardian, or any other interested person may at any time petition the court to have the emergency order set aside or modified.

(j) **Do not resuscitate (DNR).** In accordance with 43A O.S. § 10-108(A), only the court may make decisions regarding the granting or denying of consent for a DNR order, the withdrawal of hydration or nutrition, or other life-sustaining treatment.

(k) **Notice to recipient.** The court sets a date to hear the case. The hearing is scheduled within five days of the date the judge signs the notice to the recipient of protective services. The vulnerable adult must receive notice 48 hours in advance of the hearing. Notice may be waived by the court in emergency cases, as described in (2) of this subsection.

(1) A court order is issued showing OKDHS has petitioned the court for an order to provide protective services, and giving the date, time, and place of the hearing. The order specifies who serves the notice to the ~~client~~ vulnerable adult.

(2) When petitioning the court for an order for emergency protective services, OKDHS may file a motion to waive notice if there is a risk that immediate and reasonably foreseeable death or serious physical harm to the person will result from a delay. This action is authorized by 43A O.S. ~~§ 10-108(D)~~ § 10-108(D). In response, the court

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may enter a 72-hour verbal order if not during regular court hours or issue a limited order during regular hours and order written notice be served on the ~~client~~ vulnerable adult and attorney, if known, of a hearing to be held within that 72-hour period.

(3) If the hearing is declined, the court may either terminate the emergency temporary guardianship or enter a temporary 30-day order to provide involuntary protective services.

(j) **Emergency services responsibilities for out-of-home placements.** As a result of a substantiated investigation, the APS specialist develops a service plan to address the identified needs and safety issues. All out-of-home placements, including any change of placement, of ~~clients~~ vulnerable adult's under APS guardianship, are reported to and subject to approval of the court. Only protective services that are necessary to remove the conditions immediately threatening the life and well-being of the person are ordered. Protective services that may be authorized by an emergency court order include a change of residence only if the court gives specific approval for such action and names the facility in its order. Emergency placements may be made to nursing homes, personal medical institutions, other home placements, or other appropriate facilities. Emergency placement is not made to facilities for the acutely mentally ill.

(1) When the service plan recommends out-of-home placement for safety, health, and care needs, the APS specialist discusses this plan with the ~~client~~ vulnerable adult. The ~~client~~ vulnerable adult is provided with all the information necessary to make an informed decision. This may include visits to a variety of placement options arranged or facilitated by the APS specialist. The ~~client's~~ vulnerable adult's family, if appropriate and approved by the ~~client~~ vulnerable adult, is included in the planning stages. The ~~client~~ vulnerable adult or family is provided with all the information available to the APS specialist regarding the quality of care provided by the identified and selected placement.

(2) Information on current quality issues of specific nursing facilities are obtained from a variety of sources to determine the appropriateness of a facility for a ~~client~~ vulnerable adult receiving APS services. Placements are determined by the local APS specialist and ~~supervisor~~ APS specialist IV, with approval from the county director and area APS program field liaison representative (PFR). If a facility has any Oklahoma State Department of Health (OSDH) deficiencies at or above the actual harm level, or has had more than three substantiated Long Term Care Investigations (LTCI) reports in the past year, the placement must be approved by the Family Support Services Division (FSSD) APS Unit.

(m) **Restricted visitation.** Supervised or restricted visitation with the vulnerable adult may be put in place only by court order as mandated in 43A O.S. § 10-111 when:

(1) consistent with the welfare and safety of a vulnerable adult; or

(2) the vulnerable adult needs protection as the OKDHS investigation determined that maltreatment occurred.

(kn) **Time limits for providing involuntary emergency protective services.** Protective services under an emergency court order other than a 72-hour order may be provided for 30 days. If the APS specialist determines protective services are required past this 30-day period, a petition is filed for continuation of involuntary protective services in accordance with (fo) of this Section.

(fo) **Continuation of services.** Continuation of services is authorized by 43A O.S. § ~~10-108.L~~ 10-108(L).

(1) If, upon expiration of the original 30-day order, the vulnerable adult continues to require protective services, OKDHS immediately files a motion for the court to order either or both:

- (A) appointment of a guardian; and
- (B) commitment of the vulnerable adult to a nursing home, personal medical institution, home placement, or other appropriate facility other than a facility for the acutely mentally ill.

(2) Before the court enters a ~~six-month~~ 180 calendar day order for continued protective services, the court directs that a ~~comprehensive~~ an evaluation of the vulnerable adult is conducted and submitted to the court within 30 days at a review hearing. The evaluation ~~includes~~ shall include at least:

- (A) the address where the person resides and the name of any persons or agencies presently providing care, treatment, or services;
- (B) a summary of the professional treatment and services provided the person by OKDHS or other agency, if any, in connection with the problem creating the need for protective services; and
- (C) a medical, psychological or psychiatric, and social evaluation and review, including recommendations for or against maintenance of partial legal rights and recommendations for placement consistent with the least restrictive environment required.

(3) The original order continues in effect until the evaluation is submitted and the hearing is held on the motion.

(4) Notice of this hearing is served as described in subsection (k).

(5) The APS specialist is responsible for assembling the required information and submitting it to the court of jurisdiction.

(6) When an investigation indicates that the vulnerable adult is likely to need assistance with his or her affairs for an extended period of time, consideration is given to identifying a relative, friend, or other person interested in the well-being of the ~~client~~ vulnerable adult to serve as permanent guardian. Any person interested in the welfare of a person believed incapacitated or partially incapacitated may file a guardianship petition with the court. Procedures for filing the petition are given in 30 O.S. § 3-101, the Oklahoma Guardianship and Conservatorship Act. Interested persons are referred to the office of the district court ~~clerk~~ for further information and assistance.

(7) If the alleged victim's mental state is in question, the APS specialist may request the court to order a psychological or psychiatric evaluation.

(~~mp~~) **Continuation of services for an additional period.** If after the hearing the vulnerable adult is found in need of continued protective services, the court issues an order to continue the temporary guardianship to provide specified protective services for an additional period not to exceed 180 calendar days, as authorized by 43A O.S. § 10-108. If after the 180 calendar days the vulnerable adult is still found in need of protective services, the court may renew the order every 180 days as needed.

(~~mq~~) **Sale of real property.** In the event that temporary guardianship extends for more than one year or the client vulnerable adult owns real property that must be sold in order to qualify for SoonerCare (Medicaid), OKDHS may as temporary guardian sell the real property of the vulnerable adult pursuant to the provisions of the Oklahoma Guardianship and Conservatorship Act and as directed by the OKDHS ~~Legal Division~~ Office of General Counsel. The fact that the vulnerable adult would be in jeopardy for receipt of SoonerCare (Medicaid) if the property was not sold shall be stated in the court order directing the sale of the real property.

(~~mr~~) **Sale of personal property.** The court may issue an order authorizing OKDHS to sell personal property of a vulnerable adult when additional resources are required to pay for necessary care for the vulnerable adult.

(~~ps~~) **Responsibilities of the temporary guardian of the person or estate.** The APS specialist as temporary guardian is responsible for ensuring, to the extent possible, protection of the client-vulnerable adult residence, resources, and belongings. This includes:

- (1) securing the residence, checking and gathering the mail, and feeding or arranging for care for the client's vulnerable adult's domestic animals or livestock;
- (2) inventorying the client's vulnerable adult's home and personal property, using a camera where available.
 - (A) For enhanced accountability a minimum of two people must be present during the inventory, one of whom is a law enforcement representative or non-OKDHS employee.
 - (B) All persons present during the inventory must sign a document attesting to the authenticity of the inventory and/or the photographic record noting the date and their professional affiliation;
- (3) establishing an account at a local financial institution and depositing any cash and uncashed checks; and
- (4) securing other valuables located during the inventory. The APS specialist:
 - (A) arranges to have the locks changed or padlocks the residence to secure it from intrusion, if necessary; and
 - (B) advises all parties that no one is allowed to enter the residence unless accompanied by a representative of OKDHS, for as long as the temporary guardianship is in effect.

(~~qt~~) **Additional responsibilities of temporary guardian of the estate.** The APS specialist responsible for the temporary guardianship of the estate:

- (1) opens a guardianship account in a local financial institution and regularly collects and deposits monies due to the client vulnerable adult;
- (2) submits an accounting to the court as ordered by the court, no less than annually;
- (3) works with the court, the client's vulnerable adult's attorney, the DA, and the OKDHS ~~Legal Division~~ Office of General Counsel to obtain a professional accountant to manage the estate; and
- (4) absent the availability of professional financial management, is responsible for regular financial activities as dictated by the client's vulnerable adult's circumstances, which include, but are not limited to, the timely:
 - (A) payment and documentation of the client's vulnerable adult's expenses, and other bills as they occur.
 - (B) deposit of funds received;
 - (C) redirection of incoming funds to the new account; and
 - (D) protection of existing accounts.

(~~ru~~) **Responsibility of APS specialist - involuntary protective services.** In cases where temporary guardianship of the person has been granted to OKDHS, the APS specialist provides, arranges, or facilitates the protective services ordered by the court. This may include, but is not limited to:

- (1) hiring of in-home caregivers to provide in-home care and protection for the client-vulnerable adult;
- (2) placement in a medical facility for treatment of health related problems;
- (3) placement in a safe and anonymous location;
- (4) placement in a facility for either short or long term care needs. Long term care facilities include:
 - (A) residential care facilities;
 - (B) group homes;
 - (C) nursing homes;
 - (D) intermediate care facilities for persons with mental retardation;
 - (E) assisted living centers;
 - (F) skilled nursing facilities; or
 - (G) any other type of facility licensed to provide 24-hour care and/or services for vulnerable adults;
- (5) making application or completing reviews for any state or federal programs on behalf of the vulnerable adult for which he or she is or may be eligible to receive; or
- (6) making arrangements for facilities to be paid from the client's vulnerable adult's funds or resources.

(~~sv~~) **Responsibility of APS specialist - emergency out-of-home placement - ex-parte hearing.** When an emergency situation requires immediate placement, the APS specialist places the client-vulnerable adult in a licensed facility that, to the best of the APS specialist's knowledge, provides the required services needed to ameliorate the current emergency situation. Reasons for this choice are documented in the case record and provided to the court at the 72-hour hearing.

(~~tw~~) **Enforcement of involuntary court orders.** To enforce an involuntary order of protective services, ~~Section 43A O.S. §~~

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10-108 of Title 43-A of the Oklahoma Statutes provides that the court may order:

- (1) forcible entry of the premises of the vulnerable adult to be protected;
- (2) transportation of the vulnerable adult to another location; or
- (3) the eviction of a person from any property owned, leased, or rented by the vulnerable adult and restricting that person from further access to any property of the vulnerable adult.

(x) Dismissal of involuntary court orders. When the vulnerable adult is subject to an involuntary court order and OKDHS serves in the role of temporary guardian, after the temporary order has expired, the APS specialist is responsible for responding to a court's request to dismiss the guardianship by preparing a motion for the attorney representing OKDHS's consideration for an order of dismissal when it is no longer needed.

340:5-5-7. Termination of adult protective services

Adult protective services are terminated when the situation that prompted the referral has been remedied and the ~~client's~~ vulnerable adult's circumstances are stable. Cases for ~~Adult Protective Services (APS) clients~~ vulnerable adults for whom the Oklahoma Department of Human Services has a current guardianship or remand are terminated only when the court case is terminated. These cases remain active and follow-up activities are documented as required by ~~OAC 340:5-1-3(1)~~ OAC 340:5-5-3(10) as long as the court order is in effect.

340:5-5-8. Case destruction

The destruction of the Adult Protective Services (APS) paper files is done in accordance with the rules set by Archives and Records.

[OAR Docket #10-458; filed 3-31-10]

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

[OAR Docket #10-459]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

340:15-1-4 [AMENDED]

(Reference APA WF 09-23)

AUTHORITY:

Commission for Human Services, Article XXV, Sections 2 and 4 of the Oklahoma Constitution; Sections 161 et seq. of Title 56 of the Oklahoma Statutes; and Section 15 of Title 7 of the Oklahoma Statutes.

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n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The proposed revisions to Chapter 15 amend the rules to add: (1) language to give a \$500 earned income disregard for applicants and recipients of the State Supplemental Payment (SSP) Program who are blind; and (2) clarifying language.

CONTACT PERSON:

Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

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 JUNE 1, 2010:

340:15-1-4. State Supplemental Payment plan

The State Supplemental Payment (SSP) plan for the aged, blind, or disabled encompasses the requirements listed in (1) through (11) of this subsection.

- (1) **State-wide operation.** The plan is in effect in all counties of Oklahoma as a state-administered program.
- (2) **Financing.** The State of Oklahoma provides all the money for financing the SSP Program.
- (3) **Single state agency.** The SSP Program is administered by the Oklahoma Department of Human Services (OKDHS) with an office in each county in the state, operating under rules adopted by the Oklahoma Commission for Human Services (Commission).
- (4) **Fair hearings.** An applicant or recipient of SSP is provided an opportunity for a fair hearing when:
 - (A) the application is denied or is not acted upon with reasonable promptness;
 - (B) he or she is dissatisfied with the amount of his or her payment; or
 - (C) he or she disagrees with any other action taken in regard to his or her payment.
- (5) **Proper and efficient administration.** OKDHS operates under the State Merit System which establishes and maintains personnel standards on a merit basis for certain state agencies, including OKDHS. Employees of OKDHS engaged in the administration of the Combined State Plan are covered by the Merit System.
- (6) **Safeguarding of information.** In accordance with Section 183 of Title 56 of the Oklahoma Statutes and OAC

340:1-1-20, OKDHS restricts the use of or disclosure of information concerning SSP applicants and recipients to purposes directly connected with the administration of this program.

- (7) **Right to apply.** A person has the right to:
 - (A) make application for any category of assistance he or she chooses;
 - (B) expect an investigation of eligibility; and
 - (C) expect a reasonably prompt decision in regard to his or her application.

(8) **Assistance under only one program.** An eligible person can have his or her needs included in only one SSP or Temporary Assistance for Needy Families (TANF) benefit.

(9) **Standards for determining eligibility and amount of payment.** Uniform policies for determination of eligibility and the amount of payment are provided in OAC 340 Chapters 15 and 65 and OKDHS Appendix C-1, Maximum Income, Resource, and Payment Standards.

(A) SSP standards are based on the mandatory "Pass-Along Provision" of Section 1618 of the Social Security Act which requires states to pass along cost of living adjustments (COLA) in Supplemental Security Income (SSI) benefits. The Commission approves adjustments in individual payments to maintain total expenditures for SSP in a calendar year at the same level as the total expenditures for SSP in the previous year.

(B) Maximum income and resource standards for persons who are aged, blind, or disabled are based on the federal benefit rates (FBR) shown on OKDHS Appendix C-1, Schedule VIII.

(i) Countable income for SSP must be less than 100% of the FBR plus the maximum SSP amount.

(ii) Countable income must be equal to or less than 300% of the FBR for certain persons who since December, 1973:

(I) were approved for care and continuously living in a licensed Title XIX nursing care facility, intermediate care facility (ICF), or ICF for the mentally retarded (ICF/MR);

(II) have continuously received Home and Community-Based Waiver Services for the Mentally Retarded; or

(III) were patients 65 or older and have continuously resided in a mental hospital.

(iii) Countable income for deeming income to a minor child who is blind or disabled must be less than 100% of the FBR.

(iv) Maximum resources must be equal to or less than 100% of the SSI resource standards.

(10) **Income and resources.** The purpose of the SSP is to supplement income the person is receiving. OKDHS, in determining need for an aged, blind, or disabled person, takes into consideration any available income and resources of the person in accordance with rules at OAC 317:35-5-41 and 317:35-5-42 and federal and state law. In

accordance with Section 15 of Title 7 of the Oklahoma Statutes, the first \$500 of monthly earned income is disregarded for blind persons in addition to the usual earned income disregards described at OAC 317:35-5-42(d)(1).

(11) **Civil rights.** The SSP Program is administered in accordance with the provisions of Title VI of the Civil Rights Act.

[OAR Docket #10-459; filed 3-31-10]

**TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
CHAPTER 15. CONSUMER RIGHTS**

[OAR Docket #10-546]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions

450:15-1-1. Purpose [AMENDED]

450:15-1-2. Definitions [AMENDED]

Subchapter 3. Consumer Rights

Part 1. Mental Health and Drug or Alcohol Abuse Services Consumer Bill of Rights

450:15-3-8. Right to freedom from mistreatment, abuse and neglect [AMENDED]

Part 3. Consumer Grievance Procedure

450:15-3-45. Consumer grievance policy and procedures [AMENDED]

Part 11. Resident Rights, Mental Health Residential Care Facilities

450:15-3-81. Resident rights [AMENDED]

Subchapter 7. Office of Consumer Advocacy

Part 1. Duties [AMENDED]

450:15-7-2. Office of Consumer Advocacy purpose and authority [AMENDED]

450:15-7-3. Advocate General [AMENDED]

450:15-7-4. ODMHSAS facility advocacy [AMENDED]

Part 2. Investigations

450:15-7-6. Reporting suspected maltreatment [AMENDED]

450:15-7-7. Administrator's responsibilities regarding allegations reportable to the Office of Consumer Advocacy [AMENDED]

450:15-7-8. Processing reports of maltreatment received by the Office of Consumer Advocacy [AMENDED]

450:15-7-9. Investigation procedures [AMENDED]

450:15-7-10. Rights and responsibilities of accused individuals [AMENDED]

450:15-7-11. Responsibilities [AMENDED]

450:15-7-12. Educational employees [AMENDED]

450:15-7-14. Investigative interviews [AMENDED]

450:15-7-15. Investigative report and findings [AMENDED]

AUTHORITY:

Oklahoma Department of Mental Health and Substance Abuse Services Board; 43A O.S. §§ 2-101, 2-108 and 2-109.

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N/A

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

In accordance with the Administrative Procedures Act the proposed rule revisions to Chapter 15 are part of the Department's review of Title 450. The proposed rules clarify existing rules and are intended to comply with statutory changes.

CONTACT PERSON:

Stephanie Kennedy, Administrative Rules Liaison, Department of Mental Health and Substance Abuse Services, Post Office Box 53277, Oklahoma City, Oklahoma 73152-3277, (405) 522-3871.

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 JULY 1, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

450:15-1-1. Purpose

This Chapter implements 43A O.S. §§ 2-108, 2-109 and addresses the rights of individuals receiving services, either voluntarily or involuntarily from facilities operated by, certified by or under contract with, the Department of Mental Health and Substance Abuse Services, ~~and~~ outlines the rules governing the operation of the ODMHSAS Office of Consumer Advocacy, ~~and including~~ addresses investigations of alleged consumer rights violations conducted by ~~that Office~~ the Department.

450:15-1-2. Definitions

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

"Abuse" means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a consumer by staff responsible for the consumer's health, safety, or welfare, including but not limited to:

- (A) non-accidental physical injury or mental anguish;
- (B) sexual abuse;
- (C) sexual exploitation;
- (D) use of mechanical restraints without proper authority;
- (E) the intentional use of excessive or unauthorized force aimed at hurting or injuring the consumer; or
- (F) deprivation of food, clothing, shelter, or health-care by staff responsible for providing these services to a consumer.

"Advocate" means an employee of the Office of Consumer Advocacy, who provides assistance to consumers in exercising their rights, listens to their concerns, encourages them to speak for themselves, seeks to resolve problems, helps protect their rights, ~~conducts investigations~~ and seeks to improve the quality of the consumer's life and care.

"Advocate General" means the chief administrative officer of the ODMHSAS Office of Consumer Advocacy.

"Board" means Board of Mental Health and Substance Abuse Services.

"Community mental health center" or "CMHC" means a facility offering a comprehensive array of community-based mental health services, including but not limited to, inpatient treatment, outpatient treatment, partial hospitalization, emergency care, consultation and education; and, certain services at the option of the center, including, but not limited to, prescreening, rehabilitation services, pre-care and aftercare, training programs, and research and evaluation.

"Consumer" means an individual, adult or child, who has applied for, is receiving or has received mental health or substance abuse evaluation or treatment services from a facility operated or certified by ODMHSAS or with which ODMHSAS contacts.

"Consumer committee" or "Consumer government" means any established group within the facility comprised of consumers, led by consumers and which meets regularly to address consumer concerns to support the overall operations of the facility.

"Correctional institution" means any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house or residential community program operated by, or under contract to, the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense, or other persons held in lawful custody. Other persons held in lawful custody includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial.

"Crisis stabilization" means emergency, psychiatric, and substance abuse services for the resolution of crisis situations and may include placement of an individual in a protective environment, basic supportive care, and medical assessment, and, if needed, referral to an ODMHSAS certified facility having nursing and medical support available.

"Department" or "ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse services.

"Designated record set" means health information, in any medium including paper, oral, video, electronic, film, audio and digital, maintained by or for facilities operated by ODMHSAS for the purpose, in whole or in part, for making decisions about a consumer, that is:

- (A) The medical records about a consumer including but not limited to the intake, screenings, assessments, history and physical examination, psychosocial evaluation, consultation report(s), treatment and continuing care plan, medication record(s),

progress notes, psychometric/psychological testing results, discharge assessment, discharge plan, discharge summary, physician orders, immunization record(s), laboratory reports, ancillary therapy notes and reports, and case management records; or

(B) The eligibility, billing and payment information and minimum data sets maintained by or for the facility.

(C) Records that are sometimes filed with the medical records but are not part of the designated record set include:

- (i) Administrative records including court commitment paperwork, critical incident reports or peer review documents; and
- (ii) Information compiled in anticipation of litigation.

"Emergency detention" means the detention of a person who appears to be a person requiring treatment in a facility approved by the Commissioner of Mental Health and Substance Abuse Services as appropriate for such detention after the completion of an emergency examination and a determination that emergency detention is warranted for a period not to exceed seventy-two (72) hours, excluding weekends and holidays, except upon a court order authorizing detention beyond a seventy-two-hour period or pending the hearing on a petition requesting involuntary commitment or treatment as provided by 43A of the Oklahoma Statutes.

"Emergency examination" means the examination of a person who appears to be a mentally ill person, an alcohol-dependent person, or drug-dependent person and a person requiring treatment, and whose condition is such that it appears that emergency detention may be warranted, by a licensed mental health professional to determine if emergency detention of the person is warranted.

"Exploitation" or **"exploit"** means an unjust or improper use of the resources of a consumer for the profit or advantage, pecuniary or otherwise, of a person other than the consumer through the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense.

"Facility" means a public or private agency, corporation, partnership, or other entity operated or certified by ODMHSAS or with which ODMHSAS contracts to provide the physical custody, detention or treatment of consumers.

"Guardian" means a person appointed by a court to ensure the essential requirements for the health and safety of an incapacitated or partially incapacitated person. As used in this subchapter, guardian includes a general or limited guardian of the person, a general or limited guardian of the estate, a special guardian, and a temporary guardian.

~~**"Licensed mental health professional" or "LMHP"** means:~~

- ~~(A) a psychiatrist who is a diplomate of the American Board of Psychiatry and Neurology;~~
- ~~(B) a physician licensed pursuant to Section 480 et seq. or Section 620 et seq. of Title 59 of the Oklahoma Statutes who has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions;~~

~~(C) a clinical psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists;~~

~~(D) a professional counselor licensed pursuant to Section 1901 et seq. of Title 59 of the Oklahoma Statutes;~~

~~(E) a person licensed as a clinical social worker pursuant to the provisions of the Social Worker's Licensing Act;~~

~~(F) a licensed marital and family therapist as defined in Section 1925.1 et seq. of Title 59 of the Oklahoma Statutes;~~

~~(G) a licensed behavioral practitioner as defined in Section 1930 et seq. of Title 59 of the Oklahoma Statutes;~~

~~(H) an advanced practice nurse as defined in Section 567.1 et seq. of Title 59 of the Oklahoma Statutes specializing in mental health; or~~

~~(I) a physician's assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.~~

"Licensed mental health professional" or "LMHP" as defined in Title 43A §1-103 (11).

"Maltreatment" is used collectively in this Subchapter to refer to abuse, neglect, exploitation, mistreatment, sexual abuse or exploitation, and rights violation.

"Minor" means any person under the age of 18 years except any person convicted of a crime specified in Section 7306-1.1 of Title 10 of the Oklahoma Statutes or any person who has been certified as an adult pursuant to Section 7303-4.3 of Title 10 and convicted of a felony.

"Mistreatment" means an act or omission that results in or creates an unreasonable risk of harm to a consumer and that also:

- (A) violates a statute, regulation, written rule, procedure, directive, or accepted professional standards and practices; or
- (B) unintentional excessive or unauthorized use of force.

"Money" means any legal tender, note, draft, certificate of deposit, stock, bond, check or credit card.

"Neglect" means:

- (A) the failure of staff to provide adequate food, clothing, shelter, medical care or supervision which includes, but is not limited to, lack of appropriate supervision that results in harm to a consumer;
- (B) the failure of staff to provide special care made necessary by the physical or mental condition of the consumer;
- (C) the knowing failure of staff to provide protection for a consumer who is unable to protect his or her own interest; or
- (D) staff knowingly causing or permitting harm or threatened harm through action or inaction that has resulted or may result in physical or mental injury.

"Oklahoma Administrative Code" or "OAC" means the publication authorized by 75 O.S. §256 known as The

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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.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"Program of Assertive Community Treatment" or "PACT" is a clinical program that provides continuous treatment, rehabilitation, and support services to persons with mental illness in settings that are natural to the consumer.

"Privacy Officer" means the employee of ODMHSAS designated to provide guidance on state and federal privacy laws.

"Program" means a structured set of activities designed and structured to achieve specific objectives relative to the needs of the clients.

"Resident" means a person residing in a residential care facility certified by ODMHSAS.

"Resident committee" or "Resident government" means any established group within the facility comprised of residents, led by residents and which meets regularly to address resident concerns to support the overall operations of the facility.

"Residential care facility" or "RCF" means any house, home, establishment or institution licensed pursuant to the provisions of the Oklahoma Residential Care Home Act 63 O.S., §§1-819 through 1-840, other than a hotel, fraternity or sorority house, or college or university dormitory, which is certified pursuant to 43 O.S. §3-315 as a Community Residential Mental Health Facility and offers or provides residential accommodations, food service and supportive assistance to its residents or houses any resident requiring supportive assistance that are ambulatory, essentially capable of managing their own affairs and not routinely requiring nursing care or intermediate care.

"Restraint" refers to manual, mechanical and chemical methods that are intended to restrict the movement or normal functioning of a portion of an individual's body.

"Seclusion" means the placement of an individual or individuals alone in a room or other area from which egress is prevented by a physical barrier.

"Sexual abuse" includes:

- (A) rape, incest, or lewd and indecent acts or proposals, as defined by state law, by staff;
- (B) oral, anal or vaginal penetration of a consumer by staff;
- (C) the anal or vaginal penetration of a consumer by staff with any other object; or
- (D) for the purpose of sexual gratification, the touch, feeling or observation of the body or private parts of a consumer by staff; or
- (E) indecent exposure by staff providing services to the consumer.

"Sexual exploitation" by staff with regard to a consumer includes:

(A) staff allowing, permitting or encouraging a consumer to engage in sexual acts with others or prostitution, as defined by state law, which results in harm to a consumer; or

(B) staff allowing, permitting, encouraging, or engaging in the lewd, obscene or pornographic photographing, filming or depicting of a consumer in those acts as defined by state law.

"Staff" means an agent or employee of a public or private institution or facility responsible for the care of a client or consumer and providing services to the client or consumer.

"Treatment Advocate" is a family member or other concerned individual designated by a consumer to participate in treatment and discharge planning, and acts in the best interest of and serves as an advocate for the consumer.

"Verbal Abuse" means the use of words, sounds, or other communication including, but not limited to, gestures, actions or behaviors by staff that are likely to cause a reasonable person to experience humiliation, intimidation, fear, shame or degradation.

SUBCHAPTER 3. CONSUMER RIGHTS

PART 1. MENTAL HEALTH AND DRUG OR ALCOHOL ABUSE SERVICES CONSUMER BILL OF RIGHTS

450:15-3-8. Right to freedom from mistreatment, abuse and neglect

(a) Staff shall not mistreat, physically, sexually, verbally or otherwise abuse any consumer. Visitors or other consumers shall not be permitted to physically, sexually, verbally or otherwise abuse any consumer. Staff shall not neglect any consumer.

(b) The facility director shall ensure a critical incident report is completed for each alleged occurrence of abuse or neglect and a copy is forwarded to the ODMHSAS division that is designated Office of Consumer Advocacy for to review or investigation investigate allegations of mistreatment, abuse or neglect.

(c) In cases of sexual or physical abuse, the person in charge of the facility shall promptly inform the County Sheriff or the District Attorney so that a criminal investigation can be initiated.

PART 3. CONSUMER GRIEVANCE PROCEDURE

450:15-3-45. Consumer grievance policy and procedures

Facilities shall have a written grievance policy that includes:

- (1) A written notice of the grievance procedure is provided to each consumer or guardian and, to an individual of the consumer's choice;

- (2) Time frames for the grievance procedures which allow for an expedient resolution of consumer grievance(s);
 - (A) Inpatient and residential programs shall be a seven (7) day timeframe;
 - (B) Outpatient, intensive outpatient and day treatment programs shall be a fourteen (14) day timeframe;
 - (C) Crisis stabilization, medical detoxification and social detoxification programs shall have a three (3) day timeframe;
- ~~(3) The provision of written notification to the consumer of the grievance outcome and mechanism by which an individual may appeal the outcome;~~
- ~~(4) ODMHSAS operated facility procedures shall include a process by which the consumer may appeal the grievance outcome to the Consumer Advocacy Division. The Consumer Advocacy Division shall develop procedures for such external appeals;~~
- ~~(5) A procedure for advising the consumer he or she has the right to make a complaint to the ODMHSAS Consumer Advocacy Division and the mechanism for contacting the Consumer Advocacy Division;~~
- ~~(6) Name(s) of the individual(s) responsible for coordinating the program's grievance procedure and the individual responsible for or authorized to make decisions for resolution of the grievance. In the instance where the decision making is the subject of a grievance, decision making authority shall be delegated;~~
- (5) The provision of written notification to the consumer of the grievance outcome and mechanism by which an individual may appeal the outcome;
- (6) ODMHSAS operated facility procedures shall include a process by which the consumer may appeal the grievance outcome to the Commissioner or designee;
- (7) A mechanism to monitor the grievance process and improve performance based on outcomes;
- (8) An annual review of the grievance policy and procedure; and
- (9) The ongoing monitoring of the grievance process and, based on outcomes, adjust and improve processes.

PART 11. RESIDENT RIGHTS, MENTAL HEALTH RESIDENTIAL CARE FACILITIES

450:15-3-81. Resident rights

- (a) Each resident shall have and enjoy all constitutional and statutory rights of all citizens of the State of Oklahoma and the United States, unless abridged by due process of law by a court of competent jurisdiction. Each facility shall insure each resident has the rights specified as follows.
 - (1) Each resident has the right to be treated with respect and dignity. This shall be construed to protect and promote human dignity and respect for individual dignity.
 - (2) Each resident has the right to a safe, sanitary, and humane living environment.

- (3) Each resident has the right to a humane psychological environment protecting them from harm, abuse, and neglect.
- (4) Each resident has the right to an environment which provides reasonable privacy, promotes personal dignity, and provides opportunity for the client to improve his or her functioning.
- (5) Each resident has the right to receive services suited to his or her condition and needs for treatment without regard to his or her race, religion, gender, ethnic origin, age, degree of disability, handicapping condition, legal status, sexual orientation.
- (6) Each resident, on admission, has the absolute right to communicate his or her change of address with a relative, friend, clergy, or attorney, by telephone or mail.
- (7) Each resident shall have and retain the right to confidential communication with an attorney, personal physician, or clergy.
- (8) Each resident has the right to uncensored, private communications including, but not limited to, letters, telephone calls, and personal visits. Copies of any personal letter, sent or received, by a resident shall not be kept in his or her clinical record.
- (9) No resident shall ever be neglected or sexually, physically, verbally, or otherwise abused.
- (10) Each resident has the right to easy access to his or her personal funds on deposit with the facility, and shall be entitled to an accounting for said funds. A limitation on access to such funds may be made when it is determined, and documented, as essential to prevent the resident from unreasonably and significantly dissipating their assets.
- (11) Each resident has the right to have his or her own clothing and personal possessions. This right may be forfeited, or limited, only if the personal property is determined to be potentially dangerous to the client, or others, or if the property is determined to be functionally unsafe.
- (12) Each resident shall have the right to practice his or her own religious beliefs, and afforded the opportunity for religious worship. No client shall ever be coerced into engaging in, or refraining from, any personal religious activity, practice, or belief.
- (13) The records of each resident shall be treated in a confidential manner.
- (14) Each resident has the right to refuse to participate in any research project or medical experiment without informed consent of the resident, as defined by law. A refusal to participate shall not affect the services available to the resident.
- (15) A resident may voluntarily participate in work therapy, and shall be paid just compensation for such participation. However, each resident is responsible for personal care and housekeeping tasks without compensation.
- (16) The community residential mental health facility shall provide residents who are leaving at the request of the community residential mental health facility all funds and property belonging to him or her at the time of his or her departure.

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(17) Each resident shall have the right to establish and to participate in a resident committee or resident government.

(18) Each resident has the right to assert grievances with respect to any alleged infringement of these stated rights of residents, or any other subsequently statutorily granted rights.

(19) No resident shall ever be retaliated against, or subject to, any adverse conditions because of having asserted his or her rights as aforesaid in this section.

(b) Each affected facility shall have written policy and implementing procedures, and shall provide documented staff training to insure the implementation of each and every resident right stated in this section.

(c) Each affected facility shall have written policy and implementing procedures to insure each resident enjoys, and has explained to him or her, these rights; and these rights are visibly posted in both resident and public areas of the facility.

(d) The ~~ODMHSAS Office of Consumer Advocacy Department~~, in any investigation or monitoring shall have access to residents, RCF records and RCF staff as set forth in OAC 450:15-7-3.

SUBCHAPTER 7. OFFICE OF CONSUMER ADVOCACY AND DEPARTMENT INVESTIGATIONS

PART 1. ~~DUTIES~~ OFFICE OF CONSUMER ADVOCACY

450:15-7-2. Office of Consumer Advocacy purpose and authority

(a) The ~~Office of Consumer Advocacy Board~~ is authorized by 43A O.S. § ~~2-108 2-109~~ to conduct investigations on behalf of the Board to determine if a client or consumer of services from a facility operated by, certified by or under contract with the Department has been wrongfully deprived of liberty or cruelly, negligently or improperly treated or has had inadequate provisions made for the his or her medical care, supervision and safe keeping, to establish the Office of Consumer Advocacy within the Department.

(b) The Office of Consumer Advocacy shall ~~conduct investigations into allegations of physical abuse, neglect, exploitation, mistreatment, sexual abuse and other consumer rights violations carry out the powers and duties of the Office of Consumer Advocacy as set forth in this Subchapter.~~

(c) The Office of Consumer Advocacy shall ~~conduct investigations for the purpose of having an independent and objective administrative investigation of suspected consumer maltreatment in order to protect consumers from further maltreatment, to deter and prevent maltreatment, to rule out unfounded allegations and to allow the Board and the Department to hold violators accountable.~~

450:15-7-3. Advocate General

The Advocate General shall be an attorney appointed by the Board. He or she is responsible for the Office of Consumer

Advocacy and coordinates its system-wide implementation. The Advocate General shall have the following powers and duties:

(1) To serve as an advocate for consumers. ~~If a consumer needs legal counsel, the Advocate General shall advise the consumer of his or her right to seek counsel and refer the individual to counsel, if necessary.~~

(2) To ~~supervisory~~ supervise personnel assigned to the Office of Consumer Advocacy.

(3) ~~To monitor and review grievance procedures in facilities operated by, subject to certification by or under contract with the Department.~~

(4) ~~To investigate unresolved grievances and allegations of improper treatment of individuals receiving services from facilities operated by, subject to certification by or under contract with the Department.~~

(5) ~~To access facilities operated by, subject to certification by or under contract with the Department. Reasonable access shall be granted for the purposes of conducting investigations of abuse, neglect and improper treatment and performing other activities as necessary to monitor care and treatment provided by such facilities. These investigations may be unannounced and or unscheduled as determined by the Advocate General Department.~~

(6) ~~To access and copy necessary records of individuals receiving services from facilities operated by, subject to certification by or under contract with the Department. Records that are confidential under state and federal law shall be maintained as confidential and not be redisclosed by the Advocate General.~~

(3) ~~To visit each facility that is operated by, subject to certification by or under contract with the Department at least one (1) time per fiscal year to ensure the facility has made adequate provisions for the medical care, supervision and safekeeping of all ODMHSAS consumers, and to provide a status report, either verbally or in writing, to the facility's executive director regarding the findings of such visit.~~

(7) ~~To submit a report of the results of investigations of abuse to the appropriate district attorney, licensing board and, if the individual is a juvenile in the custody of a state agency, submit a report to that state agency.~~

(8) ~~To make Make recommendations to Commissioner and provide regular or special reports regarding investigations and unresolved grievances or other issues affecting consumer rights and quality of care to the Commissioner and Board.~~

(5) ~~To carry out the powers and duties of the Office of Consumer Advocacy.~~

(9) ~~To perform other duties as assigned by the Board or Commissioner.~~

450:15-7-4. ~~ODMHSAS facility advocacy Office of Consumer Advocacy powers and duties~~

The Advocate General shall assign an Advocate to monitor and investigate ~~allegations of abuse, neglect, mistreatment or rights violations~~ the care and treatment of individuals receiving

services at each facility operated by, certified by or under contract with the ODMHSAS; and to carry out the purpose and duties of the Office of Consumer Advocacy. The Office of Consumer Advocacy shall have the following powers and duties:

- (1) To serve as an advocate for consumers and to ensure the highest quality of care to all consumers at facilities operated by, subject to certification by, or under contract with the Department.
- (2) If a consumer needs legal counsel, the Advocate shall advise the consumer of his or her right to seek counsel and refer the individual to counsel, if necessary.
- (3) To monitor his or her assigned facilities to ensure the facilities have made adequate provisions for the medical care, supervision and safekeeping of all DMHSAS consumers, and to provide a monthly status report, either verbally or in writing, to the facility's executive director regarding these issues.
- (4) To access facilities operated by, subject to certification by or under contract with the Department. Reasonable access shall be granted for the purposes of performing activities as necessary to monitor care and treatment provided by such facilities. These investigations may be unannounced and or unscheduled as determined by the Department.
- (5) To access and copy necessary records of individuals receiving services from facilities operated by, subject to certification by or under contract with the Department. Records that are confidential under state and federal law shall be maintained as confidential and not be redisclosed by the Office of Consumer Advocacy.
- (6) To be proactive in the enforcement of the provisions of the Mental Health and Substance Abuse Consumer Bill of Rights.
- (7) To timely report any issue(s) of which the Office of Consumer Advocacy becomes aware that may adversely affect consumer care through the proper chain of command, beginning at the lowest level, in order to timely resolve such issue(s).
- (8) To assist consumers in filing grievances.
- (9) To assist in transitioning consumers who are committed to the Oklahoma Forensic Center pursuant to 22 O.S. §§1175.1 et seq. to appropriate alternative placements in accordance with 22 O.S. §§1175.1. et seq.
- (10) To file habeas corpus actions on behalf of individuals receiving services from facilities operated by, subject to certification by or under contract with the Department, and appear on their behalf in civil commitment and criminal post-commitment proceedings, and appear on behalf of Department consumers in proceedings for writs of mandamus.
- (11) To monitor and review grievance procedures in facilities operated by, subject to certification by or under contract with the Department.
- (12) To assist consumers in filing grievances and to review and take appropriate action to resolve unresolved grievances and allegations of improper treatment of individuals receiving services from facilities operated by the Department.

(13) To perform other duties as assigned by the Board or Commissioner.

PART 2. INVESTIGATIONS

450:15-7-6. Reporting suspected maltreatment

(a) Reporting Requirements. ODMHSAS employees who have reason to believe that maltreatment of a consumer has occurred shall report such information to the ~~Office of Consumer Advocacy~~ ODMHSAS Inspector General. This reporting requirement also extends to employees of facilities which contract with or are certified by ODMHSAS. Persons unsure of what to report are directed call the ~~Office of Consumer Advocacy Inspector General~~ at 1-888-699-6605 1-405-522-4058 or 1-877-426-4058. Questions regarding this reporting requirement may also be made by e-mailing: InspectorGeneral@odmhsas.org.

(b) Method of Reporting. Any person obligated to report an allegation of suspected abuse, neglect, mistreatment, or exploitation of consumers shall contact the ~~Office of Consumer Advocacy Inspector General~~ in Norman, Oklahoma City, Oklahoma by telephone (1-405-573-6605 522-4058 or 1-888-699-6605 1-877-426-4058) twenty-four (24) hours a day, seven (7) days a week. Reports may also be made by e-mailing: InspectorGeneral@odmhsas.org or by faxing a critical incident report to 1-405-573-6647522-6851.

450:15-7-7. Administrator's responsibilities regarding allegations reportable to the ~~Office of Consumer Advocacy~~ Department

(a) Immediate protection for safety, health, and welfare. If the ~~Office of Consumer Advocacy Department~~ receives an allegation of maltreatment involving a consumer from anyone other than the executive director of the facility or provider responsible for the consumer, ~~Office of Consumer Advocacy the Department~~ will promptly notify the facility executive director of the allegation.

(b) Upon becoming aware of an allegation of maltreatment involving a consumer, the facility administrator shall ensure the safety, protection, and needed medical attention of any consumer named in the allegation and other consumers receiving services from the facility or provider.

(c) When criminal activity is alleged the facility executive director shall immediately notify the appropriate law enforcement authority.

450:15-7-8. Processing reports of maltreatment received by the ~~Office of Consumer Advocacy~~ Department

The ~~Office of Consumer Advocacy~~ Department shall record and keep all investigations conducted. The findings of each investigation shall be reported to the appropriate division within the Department for review and disposition.

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450:15-7-9. Investigation procedures

(a) ~~The Office of Consumer Advocacy Department~~ shall conduct a prompt investigation of the allegation and shall be subject to the ODMHSAS Investigations policy. ~~The Advocate investigator~~ shall contact the applicable facility executive director, or designee, to arrange for document production, site visits and interviews.

(b) The Department shall have the authority to access facilities operated by, subject to certification by or under contract with the Department. Reasonable access shall be granted for the purposes of conducting investigations of abuse, neglect and improper treatment. These investigations may be unannounced and or unscheduled as determined by the Department.

(bc) The applicable facility executive director, or designee, shall arrange for the ~~Advocate investigator~~ to have immediate and direct access to the alleged victim(s) in the report who is still a consumer of the facility. During an investigation, the facility shall provide the ~~Advocate investigator~~ access to all employees, consumers or clients, facilities, files and records of any nature that may pertain to the investigation. Denial of access may be grounds for termination of a contract between ODMHSAS and a contractor or revocation, non-renewal or suspension of certification or both.

(ed) Interference includes, but is not limited to:

- (1) Intimidating, harassing or threatening a party to the investigation;
- (2) Retaliation against a consumer or employee for reporting an allegations; or
- (3) Denial of ~~Advocate investigator~~ access to clients, employees, facilities, witnesses, records or other relevant information as requested by the investigator.

450:15-7-10. Rights and responsibilities of accused individuals

During the investigation process, an individual accused of maltreatment of a consumer or an individual identified to have information about the allegation(s) has the right to:

- (1) Be advised of the nature of the allegations made against him or her in the allegation;
- (2) Be advised of the investigative process involving maltreatment;
- (3) Be interviewed by ~~the Advocate~~ an investigator and allowed to give his or her position regarding the allegation;
- (4) Submit or supplement a written statement relating to the allegations;
- (5) Seek advice from other parties concerning his or her rights and responsibilities in ~~Office of Consumer Advocacy Department~~ investigations;

450:15-7-11. Responsibilities

During the investigative process, an individual accused of maltreatment of a consumer shall:

- (1) Be available for interviews and accommodate the ~~Advocate investigator~~ in scheduling of interviews;
- (2) Refrain from any action which interferes with the investigation, including any action which intimidates,

threatens, or harasses any person who has or may provide information relating to the allegation; and

(3) Provide pertinent information and respond fully and truthfully to questions asked.

(4) Refrain from intentionally misdirecting investigator by falsehoods or omissions.

450:15-7-12. Educational employees

This subsection applies to an employee of a school district providing contract educational services on-site at a facility who is either a witness or an individual accused of maltreatment of a consumer in an investigation opened by the ~~Office of Consumer Advocacy Department~~.

(1) The executive director of the facility where the incident took place shall notify the principal of the school of the nature of the allegation and the name of the assigned ~~Office of Consumer Advocacy~~ Advocate investigator.

(2) The principal of the school is responsible for notifying the school employee of the reason for the investigative interview, advising the employee of his or her rights and responsibilities relating to the ~~Office of Consumer Advocacy Department~~ investigation, and arranging for the employee's appearance at an investigative interview. This requirement is for purposes of notification and coordination of the investigative process and does not extend to ensuring the protection of the alleged victim(s) or other clients or consumers at the facility where the educational services are provided. The administrator of the facility where the alleged incident took place is responsible for protection of clients or consumers.

450:15-7-14. Investigative interviews

The ~~Advocate investigator~~ shall interview or attempt to interview persons known or identified to have information about the allegation. If an injury is alleged, the ~~Advocate investigator~~ or other appropriate person shall observe and note apparent injuries, and obtain pertinent medical documentation, including photographs. An attorney or other representative of the person being interviewed may attend an interview only as a silent observer with prior permission of the ~~Advocate General Department~~.

(1) The ~~Office of Consumer Advocacy~~ Advocate Department shall conduct a separate private interview with each alleged victim, available witnesses to the alleged maltreatment, and persons who allegedly were directly or indirectly involved in the allegation, persons with knowledge of relevant information, and each individual accused of the maltreatment. When possible, all other witnesses shall be interviewed prior to interviewing the accused individual(s).

(2) The ~~Office of Consumer Advocacy~~ investigator shall tape record interviews. Tape recordings of interviews remain with the ~~Office of Consumer Advocacy Department's~~ investigative file. ~~Office of Consumer Advocacy~~ Investigative files and tape recordings are not public documents due to the confidential and privileged information contained in the interviews.

(3) The Advocate investigator shall inform persons interviewed of the investigative process.

(4) The Advocate investigator shall verbally inform each accused individual of the allegation(s). The name of the person making the report of the allegation shall not be disclosed.

(5) During the interview with an individual accused of maltreatment of a consumer, the Advocate investigator shall provide the individual an opportunity to respond to the allegation(s). Following the initial interview, if the Advocate investigator obtains information to which the accused individual did not have an opportunity to respond, the Advocate investigator shall conduct another interview with the individual. The Advocate investigator shall advise the accused individual of the substance of the new information and provide an opportunity to present a response.

(6) If ~~the Advocate needs~~ there is a need to interview a person who is deaf, hard of hearing, or is non-English speaking, the investigator, with the assistance of the Office of Consumer Advocacy, shall arrange oral or sign language interpreter services by an independent and qualified interpreter.

(7) To schedule an interview with an accused individual, the Advocate investigator shall contact ~~by phone or regular mail~~ the executive director of the facility, or designee, or provider that employs the accused individual. If a reasonable time has passed without being able to schedule an interview, the Advocate investigator shall contact the executive director of the facility, or designee, or provider to request the employee be required to participate. If the accused individual refuses to participate in the investigation, the report shall be completed without the accused individual's statement and a finding shall be made based on available information. For other persons needing to be interviewed, the ~~Advocate investigator~~ shall follow the same.

(8) If a person fails to appear for a scheduled interview without good cause, the Advocate investigator shall complete the investigative report without interviewing that person. The investigative report shall include an explanation of why the interview was not conducted, including documentation of efforts to interview the person.

~~(9) The Advocate shall conduct an exit conference, either in person or by telephone, with the executive director when the information-gathering portion of the investigative process is completed. The Advocate shall complete the written investigative report within 30 days of the date of the exit conference and a summary letter shall be sent to the executive director of a contract or certified facility.~~

450:15-7-15. Investigative report and findings

(a) After completing the information-gathering portion of the investigative process, the Advocate investigator shall prepare a written investigative report minimally containing:

(1) The allegation(s) made to the ~~Office of Consumer Advocacy~~ Department, the location of the alleged incident(s), and the assigned ~~Office of Consumer Advocacy~~ case number;

(2) A statement of any injuries sustained by the alleged victim(s);

(3) The applicable definition(s) of the type of maltreatment at issue such as abuse, neglect, exploitation, or mistreatment;

(4) The finding(s) in accordance with subsection (b) of this Section;

(5) A list of the involved parties, their titles and role in the matter, if they were interviewed and, if so, when and if interviewed face to face or by telephone;

(6) The name, address, and telephone numbers of any interpreter used during the investigation;

(7) An explanation of the basis for the finding(s);

(8) Any areas of concern relating to the referral identified during the investigation regarding that facility, that provider, or practices or procedures which have implications for the safety, health, or welfare of clients;

(9) A list of relevant documents and records reviewed during the investigation; and

(10) A list of attachments to the report.

(b) The investigative finding options are:

(1) **"Supported"** which means the available information establishes that it is more likely than not that the alleged abuse, neglect, or mistreatment occurred;

(2) **"Unsupported"** which means the available information established that it is unlikely that the alleged abuse, neglect, or mistreatment occurred; or

(3) ~~"Unable to support"~~ **Inconclusive** which means the available information was not sufficient to establish whether or not the alleged abuse, neglect, or mistreatment occurred.

(c) Except as otherwise specifically provided in this section and as otherwise provided by state or federal laws, the information, records, materials and reports related to investigations by the ~~Office of Consumer Advocacy~~ Department are confidential and contain privileged information. Accordingly, such records, materials and reports shall not be open to public inspection nor their contents disclosed nor shall a subpoena or subpoena duces tecum purporting to compel disclosure of such information be valid pursuant to 43A O.S. §1-109(C).

(d) An order of the court authorizing the inspection, release or disclosure of information, records, material and reports related to investigations by the ~~Office of Consumer Advocacy~~ Department shall be entered by a court only after a review of the records and a determination, with due regard for confidentiality of the information and records and the privilege of the persons identified in the records that a compelling reason exists, any applicable privilege has been waived and such inspection, release or disclosure is necessary for the protection of a legitimate public or private interest.

(e) The ~~Office of Consumer Advocacy~~ Department shall provide results of investigations as follows:

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- (1) A copy of the final ~~Office of Consumer Advocacy investigation~~ investigative report shall be sent to the Commissioner, designated Deputy Commissioner, the Chief Operating Officer, the General Counsel and the executive director of a the appropriate ODMHSAS operated facility.
- (2) When an executive director of a facility that is operated by the Department is named as an individual accused of maltreatment of a consumer in the allegation, the final report will not be forwarded to that individual.
- (23) A summary of the allegation and finding shall be sent to the executive director of a ~~state certified or contract facility that is subject to certification by or under contract with the Department.~~
- (34) When an executive director of a facility that is subject to certification by or under contract with the Department is named as an individual accused of maltreatment of a consumer in the allegation, a summary of the investigative report shall not be forwarded to that individual, and the Office of Consumer Advocacy investigator shall forward a summary of the investigative report to the chair of the board of directors of the facility.
- (4) ~~A copy of all Office of Consumer Advocacy reports shall be sent to the Legal Division of the ODMHSAS.~~
- (5) A summary of the allegations and finding shall be provided to the Board and a copy of the report shall be provided upon request of the Board.
- (6) The Department shall notify the person suspected of the abuse, neglect or improper treatment and the person subject to the alleged abuse, neglect, or improper treatment of the Department's findings.
- (67) ~~Upon request, The Department or the Office of Consumer Advocacy may summarize the outcome of an investigation, stating the allegation and the finding. The summary may be provided to the person suspected of the abuse, neglect or improper treatment, the person subject to alleged abuse, neglect or improper treatment, the person who reported an allegation and the executive director of a facility certified by or under contract with the Department at which the alleged abuse, neglect, or improper treatment occurred.~~
- (f) ~~The Office of Consumer Advocacy Department shall maintain the original report, supporting documents, and pertinent recorded tapes in locked file cabinets in accordance with the applicable ODMHSAS records management and disposition plan.~~
- (g) The Department shall submit a report of the results of investigations of abuse to the appropriate district attorney and, if the individual is a juvenile in the custody of a state agency, submit a report to that state agency.

[OAR Docket #10-546; filed 4-8-10]

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

[OAR Docket #10-547]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 9. Role of State-operated Inpatient Psychiatric Units
450:30-9-3.1. Voluntary formal and informal admissions to a state-operated inpatient psychiatric unit [AMENDED]

AUTHORITY:

Oklahoma Department of Mental Health and Substance Abuse Services Board; 43A O.S. §§ 2-101, 3-306, 3-317, 3-403(1), 3-404, 3-406, 3-415 and 3-416.

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In accordance with the Administrative Procedures Act the proposed rule revisions to Chapter 30 are part of the Department's review of Title 450. The proposed rules clarify existing rules and are intended to comply with statutory changes.

CONTACT PERSON:

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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 JULY 1, 2010:

SUBCHAPTER 9. ROLE OF STATE-OPERATED INPATIENT PSYCHIATRIC UNITS

450:30-9-3.1. Voluntary formal and informal admissions to a state-operated inpatient psychiatric unit

The executive director of the state-operated inpatient unit may receive and retain as a consumer, when there are available accommodations, any person eighteen (18) years of age or over, ~~who meets the admission criteria defined in 450:30-9-3,~~ and who voluntarily makes a written application for inpatient treatment.

(1) Any person presenting to a state-operated inpatient psychiatric unit for voluntary admission shall be evaluated by a licensed mental health professional, as defined by 43A O.S. §1-103 (11), who is employed by the state-operated inpatient psychiatric unit to determine that the requested admission is appropriate in accordance with the facility's admission criteria. If the licensed mental health professional determines that admission is necessary and an appropriate referral by a community mental health center has not been made, the licensed mental health professional will seek consent from the person making application for admission to contact the local community mental health center to discuss the admission of the consumer and review options for consideration in lieu of admission to the facility.

(2) A person being admitted to the state-operated inpatient psychiatric unit on a voluntary status must be able to grant consent for the admission. The licensed mental health professional shall ensure that the person signing the request for voluntary admission is competent to grant consent. If the person is unable or not competent to give consent, then the individual may be admitted through the civil involuntary commitment process.

(3) The written application for voluntary admission shall include:

- (A) the name of facility to which the request is made;
- (B) the current date and time;
- (C) the name and address of the person making the request;
- (D) the signatures of the person making the request;
- (E) the licensed mental health professional conducting the evaluation; and
- (F) the signature of a witness or notary.

(4) An individual presenting for voluntary admission with pending criminal charges against him or her shall not be admitted if he or she is confined in a jail or adult lock-up facility.

(5) An individual voluntarily admitted to the state-operated inpatient psychiatric unit shall not be detained for a period exceeding seventy-two (72) hours, excluding weekends and holidays, from receipt of notice of the consumer's desire to leave such inpatient treatment facility.

(6) The state-operated inpatient psychiatric unit shall refer, with appropriate signed consent by the individual, persons who do not meet the criteria for admission and are refused admission to an appropriate agency or service.

Appropriate documentation of the referral and reason for the non-admission shall be made.

[OAR Docket #10-547; filed 4-8-10]

**TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
CHAPTER 55. STANDARDS AND CRITERIA FOR PROGRAMS OF ASSERTIVE COMMUNITY TREATMENT**

[OAR Docket #10-548]

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RULES:

- Subchapter 1. General Provisions
- 450:55-1-2. Definitions [AMENDED]
- Subchapter 3. Program Description and Pact Services
- 450:55-3-2. Admission criteria [AMENDED]
- 450:55-3-5. Hours of operation and staff coverage [AMENDED]
- 450:55-3-6. Service intensity [AMENDED]
- 450:55-3-7. Staffing requirements [AMENDED]
- Subchapter 5. Pact Clinical Documentation
- 450:55-5-3. Documentation of individual treatment team members [AMENDED]
- 450:55-5-5. Comprehensive assessment [AMENDED]
- 450:55-5-6. Treatment team meeting [AMENDED]
- 450:55-5-7. Treatment planning [AMENDED]
- 450:55-5-9. PACT progress note [AMENDED]
- Subchapter 11. Organizational Management
- 450:55-11-2. Program organization [AMENDED]

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CONTACT PERSON:

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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 JULY 1, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

450:55-1-2. Definitions

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

"Advanced Practice Nurse" or "APN" means an individual who is a licensed registered nurse with current certification of recognition to practice as an Advanced Practice Nurse issued by the Oklahoma Board of Nursing.

"Certified behavioral health case manager" means any person who is certified by the Department of Mental Health and Substance Abuse Services to offer behavioral health case management services as one of the three (3) classifications of case manager within the confines of a mental health facility or drug or alcohol treatment facility that is operated by the Department or contracts with the State to provide behavioral health services.

"Community-based Structured Crisis Center" or "CBSCC" means a program of non-hospital emergency services for mental health and substance abuse crisis stabilization including, but not limited to, observation, evaluation, emergency treatment and referral, when necessary, for inpatient psychiatric or substance abuse services. This service is limited to CMHC's who are certified by the Department of Mental Health and Substance Abuse Services or facilities operated by the Department of Mental Health and Substance Abuse Services.

"Clinical privileging" means an organized method for treatment facilities to authorize an individual permission to provide specific care and treatment services to consumers within well-defined limits, based on the evaluation of the individual's license, education, training, experience, competence, judgment and other credentials.

"Consumer" means an individual who has applied for, is receiving, or has received services from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in OAC Title 450 as client(s) or patient(s) or resident(s) or a combination thereof.

"Co-occurring disorder" means any combination of mental health and substance abuse symptoms or diagnoses in a client.

"Co-occurring disorder capability" means the organized capacity within any type of program to routinely screen, identify, assess, and provide properly matched interventions to individuals with co-occurring disorders.

"Credentialed Recovery Support Specialist" is a member of the PACT team who is working as a Recovery Support Specialist and has completed the ODMHSAS approved training and testing.

"Crisis intervention" means an immediately available service to meet the psychological, physiological and environmental needs of individuals who are experiencing a mental health or substance abuse crisis.

"Crisis stabilization" means emergency psychiatric and substance abuse services for the resolution of crisis situations and may include placement of an individual in a protective environment, basic supportive care, and medical assessment and, if needed, referral to an ODMHSAS certified facility having nursing and medical support available.

"Critical incident" means an occurrence or set of events inconsistent with the routine operation of the facility, or the routine care of a consumer. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries to consumers, staff and visitors; medication errors; consumers that are absent without leave (AWOL); neglect or abuse of a consumer; fire; unauthorized disclosure of information; damage to or theft of property belonging to a consumers or the facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

"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, religious, sexual orientation, and/or social group.

"DSM" means the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"FTE" means an employee, or more than one, who work(s) the time equivalent to the number of hours per week, month or year of one (1) employee working full-time.

"Governing Agency" means the facility or specific community based behavioral health provider under which the PACT program is operated.

"Historical time line" means a method by which a specialized form is used to gather, organize and evaluate historical information about significant events in a consumer's life, experience with mental illness, and treatment history.

"Individual Treatment Team" or "ITT" means the primary case manager and a minimum of two other clinical staff on the PACT team who are responsible to keep the consumer's treatment coordinated, monitor their services, coordinate staff activities and provide information and feedback to the whole team.

"Integrated Client Information System" or "ICIS" is a comprehensive management information system based on national standards for mental health and substance abuse databases. It is a repository of diverse data elements that provide information about organizational concepts, staffing patterns, consumer profiles, program or treatment focus, and many other topics of interest to clinicians, administrators and consumers. It includes unique identifiers for agencies, staff

and consumers that provide the ability to monitor the course of consumer services throughout the statewide DMHSAS network. ICIS collects data from hospitals, community mental health centers, substance abuse agencies, domestic violence service providers, residential care facilities, prevention programs, and centers for the homeless which are operated or funded in part by DMHSAS.

"Licensed Behavioral Health Professional" or "LBHP" means: 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. 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 following licensing boards: (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. 4) A Physician Assistant who is licensed in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"Licensed mental health professional" or "LMHP" as defined in Title 43A §1-103 (11).

"Linkage services" means the communication and coordination with other service providers pursuant to a valid release that assure timely appropriate referrals between the PACT program and other providers.

"Longitudinal Face Sheet" means a process that is used to track a PACT consumer's specific demographic, personal contact, treatment history and other relevant information from the time of admission until discharge.

"Licensed Practical Nurse" or "LPN" means an individual who is currently licensed by the Oklahoma Board of Nursing to provide a directed scope of nursing practice.

~~**"Mental Health Professional"** means:~~

~~(A) Physicians with a current license and board certification in psychiatry or board eligible, or a current resident in psychiatry, where the services provided to a DMHSAS funded program are within the scope of the supervised residency program. Other licensed physicians experienced in behavior health counseling practices may be considered, if the facility has verified sufficient training and experience in the areas of practice for which the ICIS service is being reported; or~~

~~(B) Practitioners with a license to practice or those actively and regularly receiving board approved supervision to become licensed by one of the following licensing boards: Psychology, Social Work (clinical specialty), Professional Counselor, Marriage and~~

~~Family Therapist, Licensed Behavioral Practitioner, or Licensed Alcohol and Drug Counselor.~~

~~(C) Advanced Practice Nurse (certified in psychiatric mental health specialty) licensed as a registered nurse with a current certification of recognition by the Oklahoma State Board of Nursing.~~

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"Oklahoma Administrative Code" or "OAC" means 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.

"Performance Improvement" or "PI" means an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of consumers and others. Synonyms, and near synonyms include continuous performance improvement, continuous improvement, organization-wide performance improvement and total quality management.

"Persons with special needs" means any person with a condition which is considered a disability or impairment under the "American with Disabilities Act of 1990" including, but not limited to the deaf and hearing impaired, visually impaired, physically disabled, developmentally disabled, persons with disabling illness, persons with mental illness. See "Americans with Disabilities Handbook," published by U.S. Equal Employment Opportunity Commission and U.S. Department of Justice.

"Primary Case Manager" is a certified behavioral health case manager assigned by the team leader to coordinate and monitor activities of the ITT, has primary responsibility to write the treatment plan and make revisions to the treatment plan and weekly schedules.

"Program Assistant" is a member of the PACT team providing duties supportive of the Team and may include organizing, coordinating, and monitoring non-clinical operations of the PACT, providing receptionist activities and coordinating communication between the team and consumers.

"Program of Assertive Community Treatment" or "PACT" means a clinical program that provides continuous treatment, rehabilitation and support services to persons with mental illness in settings that are natural to the consumer.

"Progress notes" mean a chronological description of services provided to a consumer, the consumer's progress, or lack of, and documentation of the consumer's response related to the intervention plan.

"Recovery Support Specialist" is a member of the PACT team who is or has been a recipient of mental health services for a serious mental illness and is willing to use and share his or her personal, practical experience, knowledge, and first-hand insight to benefit the team and consumers.

"Team Leader" is the clinical and administrative supervisor of the PACT team who also functions as a practicing clinician. The team leader is responsible for monitoring each consumer's clinical status and response to treatment as well as supervising all staff and their duties as specified by their job descriptions.

Permanent Final Adoptions

"Trauma informed" means the capacity for a facility and all its programs to recognize and respond accordingly to the presence of the effects of past and current traumatic experiences in the lives of its consumers.

SUBCHAPTER 3. PROGRAM DESCRIPTION AND PACT SERVICES

450:55-3-2. Admission criteria

(a) The PACT program shall maintain written admission policies and procedures that, at a minimum include the following:

(1) Priority shall be given to people with a primary diagnosis of schizophrenia or other psychotic disorders, such as schizoaffective disorder or bipolar disorder with psychotic features as defined by the current DSM; ~~DSM~~, and with at least four (4) of the following:

~~(A2)~~ At least four psychiatric hospitalizations in the past 24 months or lengths of stays totaling over 30 days in the past 12 months which can include admissions to Community-Based Structured Crisis Care; and with at least three (3) of the following:

~~(BA)~~ Persistent or recurrent severe affective, psychotic or suicidal symptoms;

~~(CB)~~ Coexisting substance abuse disorder greater than six (6) months;

~~(DC)~~ High risk of or criminal justice involvement in the past 12 months which may include frequent contact with law enforcement personnel, incarcerations, parole or probation;

~~(ED)~~ Homeless, imminent risk of being homeless or residing in substandard or unsafe housing;

~~(FE)~~ Residing in supported housing but clinically assessed to be able to live in a more independent living situation if intensive services are provided; or requiring supported housing if more intensive services are not available;

~~(GF)~~ Inability to participate in traditional office-based services or evidence that they require a more assertive and frequent non-office based services to meet their clinical needs;

~~(HG)~~ Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the community.

~~(23)~~ Individuals with a sole primary diagnosis of substance abuse, brain injury, or Axis II disorders are not appropriate for PACT.

~~(34)~~ Individuals with a history of violent behaviors may or may not be considered for admission.

(b) Compliance with 450:55-3-2 shall be determined by on-site observation and a review of the following: clinical records, ICIS information and the PACT policy and procedures.

450:55-3-5. Hours of operation and staff coverage

(a) The PACT program shall assure adequate coverage to meet consumers' needs including but not limited to:

(1) The PACT team shall be available to provide treatment, rehabilitative and support services seven days per week, including holidays and evenings, according to the following:

(A) For weekdays, Monday through Friday, the PACT team hours of operation for a team size greater than 8 FTEs, excluding the psychiatrist, the APN and program assistant, shall be two overlapping eight-hour-shifts for a total of 12 hours of coverage per day. The hours of operation for a team size of 8 FTE or less shall be a single eight-hour shift; with consumer needs as specified in the treatment plans driving any extended hours of operation.

(B) For weekends and holidays, regardless of the number of FTE's, for teams serving ten (10) to fifty (50) consumers, there shall be eight (8) hours of coverage per day with a minimum of one (1) clinical staff. For teams serving more than fifty (50) consumers, there shall be eight (8) hours of coverage per day with a minimum of two (2) clinical staff.

(2) The PACT team shall operate an after-hours on-call system. PACT shall regularly schedule PACT staff for on-call duty to provide crisis and other services during the assigned on-call hours when staff is not working to personally respond to consumers by telephone or in person on a 24 hour per day, 7 day a week basis.

(3) Psychiatric or APN backup shall also be available and on-call during all after-hours periods. If availability of the PACT team's psychiatrist during all hours is not feasible, alternative psychiatric backup shall be arranged.

(b) Compliance with 450:55-3-5 shall be determined by on-site observation and a review of the following: clinical records, ICIS information and the PACT policy and procedures.

450:55-3-6. Service intensity

(a) The PACT team is the primary provider of services and has the responsibility to meet the consumer's multiple treatment, rehabilitation and supportive needs with minimal referrals to external agencies or programs within the governing agency for services.

(b) The PACT team shall have the capacity to provide multiple contacts per week to consumers experiencing severe symptoms or significant problems in daily living.

(c) The PACT team shall minimally provide an average of three contacts per week for consumers, ~~unless otherwise clinically indicated.~~

(d) Each team shall provide at least 75 percent of service contacts in the community, in non-office or non-facility based settings.

(e) The PACT team shall provide ongoing contact when permitted by consumers who are hospitalized for drug and alcohol, physical, or psychiatric reasons. To ensure continuity of care the PACT team shall:

(1) Assist in the admission process if at all possible;

- (2) Have contact with the consumer and inpatient treatment providers within 48 hours of knowing of the inpatient admission to provide information, assessment, assist with the consumer's needs and begin discharge planning;
 - (3) Maintain a minimum of weekly face-to-face contact with the consumer and treatment team staff;
 - (4) Transition the consumer from the inpatient setting into the community; and
 - (5) Maintain at least three (3) face-to-face contacts per week for one month for consumers who are discharged from an inpatient facility. The team shall document any failed attempts.
- (f) Telephone answering devices will not be used as a primary method to receive phone calls. PACT clients shall have direct phone access to the PACT office Monday through Friday, 8:00 a.m. to 5:00 p.m. The program assistant or other PACT staff shall be available to personally answer all incoming phone calls.
- (g) Compliance with 450:55-3-6 shall be determined by on-site observation; and a review of the following: clinical records; ICIS information; and the PACT policy and procedures.

450:55-3-7. Staffing requirements

- (a) The PACT team shall include individuals qualified to provide the required services while closely adhering to job descriptions as defined in the "PACT Start-up Manual, most recent edition as published by the National Alliance for the Mentally Ill."
- (b) Each PACT team shall have the following minimum staffing configuration:
- (1) One (1) full-time team leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician in the PACT team. The team leader shall be a Licensed Mental Health Professional.
 - (2) A Board Certified or Board Eligible psychiatrist providing a minimum of 16 hours per week of direct care to minimally include: initial and psychiatric assessments, daily organizational staff meetings, treatment planning, home visits, pharmacological management, collaboration with nurses, crisis intervention, and liaison with inpatient facilities. In the initial build-up phase, a minimum of 8 hours per week shall be provided until the team is serving ten or more clients. For teams serving over 50 consumers, the Psychiatrist shall provide an additional three (3) hours per week for every fifteen (15) additional consumers admitted to the program. On-call time is not included; or An Advanced Nurse Practitioner (APN) currently certified in a psychiatric mental health specialty with current certification of recognition of prescriptive authority issued by the Oklahoma Board of Nursing, and who practices under the supervision of a licensed psychiatrist may perform the duties of the psychiatrist as allowed by State Law. The APN must provide a minimum of 16 hours per week of direct care to minimally include: initial and psychiatric assessments, daily organizational staff meetings, treatment planning, home visits, pharmacological management, collaboration with nurses, crisis

- intervention, and liaison with inpatient facilities. In the initial build-up phase, a minimum of 8 hours per week shall be provided until the team is serving ten or more clients. For teams serving over 50 consumers, the APN shall provide an additional three (3) hours per week for every fifteen (15) additional consumers admitted to the program. On-call time is not included.
- (3) At least ~~two (2)~~ one (1) full-time registered nurses and one (1) full-time licensed practical nurse. Each nurse shall have at least one (1) year of mental health experience or work a total of forty (40) hours at a psychiatric medication clinic within the first three (3) months of employment.
 - (4) At least one (1) ~~additional full-time Mental Health Professional-Licensed Behavioral health Professional~~.
 - (5) At least two (2) full-time ~~bachelor's level or higher degree certified~~ behavioral health case managers.
 - (6) At least one (1) staff member on the team, excluding the psychiatrist or APN, team leader and program assistant shall be qualified as a substance abuse treatment specialist, and at least one (1) staff member on the team, excluding the psychiatrist or APN, team leader and program assistant, shall be qualified as an employment specialist.
 - (7) A minimum of one (1) full-time or two (2) half-time (0.5 FTE) Recovery Support Specialist(s) or Credentialed Recovery Support Specialist(s). The Recovery Support Specialist(s) is/are to complete all qualifications to become a Credentialed Recovery Support Specialist within one (1) year of employment to the PACT team.
 - (8) A minimum of one (1) program assistant.
- (c) Teams serving greater than 65 consumers shall include the following additional staff:
- (1) A full-time assistant team leader who is the back-up clinical and administrative supervisor of the team and also functions as a practicing clinician in the PACT team. ~~The assistant team leader shall be a Mental Health Professional.~~
 - (2) One (1) additional full-time registered nurse.
 - (3) One (1) additional full-time ~~Mental Health Professional~~. Licensed Behavioral Health Professional.
 - (4) One (1) additional full-time ~~bachelor level certified~~ behavioral health case manager, when serving greater than 85 consumers on the team.
- (d) The PACT program shall have policies and procedures addressing the use of students, medical residents, osteopathic residents, psychiatric residents and volunteers on the team.
- (1) Psychiatric residents shall not replace the clinical work of the PACT psychiatrist or APN such as on-call coverage, pharmacological management, treatment planning or crisis intervention.
 - (2) The hours a psychiatric resident works on a PACT team shall not be counted towards the standard hours of the PACT psychiatrist or APN.
- (e) Compliance with 450:55-3-6 shall be determined by on-site observation; and a review of the following: clinical records; ICIS information; and the PACT policy and procedures.

Permanent Final Adoptions

SUBCHAPTER 5. PACT CLINICAL DOCUMENTATION

450:55-5-3. Documentation of individual treatment team members

~~(a) The PACT shall document in the clinical record the consumer was assessed to determine appropriateness of admission to PACT in accordance with the program admission criteria.~~

~~(ba)~~ The clinical record shall document the team leader has assigned the consumer a psychiatrist or APN, primary case manager, and individual treatment team (ITT) members within one (1) week of admission.

~~(eb)~~ Compliance with 450:55-5-3 shall be determined by on-site observation and a review of the following: clinical records and the PACT policy and procedures.

450:55-5-5. Comprehensive assessment

(a) The consumer's psychiatrist or APN, primary PACT case manager, and individual treatment team members shall prepare the written comprehensive assessment(s) within six (6) weeks of admission.

(b) The comprehensive ~~assessment~~ assessments shall include a written narrative report on ODMHSAS approved forms for each of the following areas:

(1) Psychiatric and substance abuse history, mental status, and a current DSM diagnosis, to be completed by the PACT psychiatrist or APN;

(2) Medical, dental, and other health needs to be completed by a PACT registered nurse;

~~(3) Integrated substance abuse assessment as well as the extent and effect of drugs or alcohol use and interaction with mental illness, plus description of periods of relative sobriety, completed by a team professional as approved by the team leader;~~

~~(4)~~ Extent and effect of any violence within the consumer's living situation(s) or personal relationships;

~~(5)~~ The current version of the Alcohol Severity Index (ASI) within the first 6 weeks of admission and as clinically indicated thereafter;

~~(6)~~ Education and employment;

~~(7)~~ Social development and functioning by a team professional as approved by the team leader;

~~(8)~~ Activities of daily living, to be completed by the team professional or Recovery Support specialist under the supervision of the team leader;

~~(9)~~ Family structure and relationships by a team professional as approved by the team leader; and

~~(10)~~ Historical timeline by all team members under the supervision of the team leader.

(c) Compliance with 450:55-5-5 shall be determined by on-site observation and a review of the clinical records, ICIS information and the PACT policy and procedures.

450:55-5-6. Treatment team meeting

(a) The PACT team shall conduct treatment planning meetings under the supervision of the team leader, or designee. These treatment planning meetings shall minimally:

(1) Convene at regularly scheduled times per a written schedule maintained by the team leader; and

(2) Occur with sufficient frequency and duration to develop written individual consumer treatment plans and to review and rewrite the ~~comprehensive~~ treatment plans every six months.

(b) Prior to writing the ~~comprehensive~~ treatment plan, the team shall meet to develop the ~~comprehensive~~ treatment plan by discussing and documenting:

(1) The specifics of all information learned from the comprehensive assessments or course of treatment; and

~~(2) Resources to carry out the treatment plan;~~

~~(3) Roles of the individual PACT members to carry out the plan; and~~

~~(4)~~ Recommendations made to the treatment plan from the consumer, family members and PACT staff.

(c) Treatment planning meetings shall be scheduled in advance of the meeting and the schedule shall be posted. The team shall assure that consumers and others designated by the consumers may have the opportunity to attend treatment planning meetings, if desired by the consumer. ~~A summary of the treatment planning meeting shall be documented in the consumer's clinical record.~~ At each treatment planning meeting the following staff should attend: team leader, psychiatrist or APN, primary case manager, individual treatment team members, and all other PACT team members involved in regular tasks with the consumer.

(d) Compliance with 450:55-5-6 shall be determined by on-site observation and a review of the following: clinical records, ICIS information and the PACT policy and procedures.

450:55-5-7. Treatment planning

(a) The PACT team shall evaluate each consumer and develop an individualized comprehensive treatment plan within eight (8) weeks of admission, which shall identify individual needs and problems and specific measurable goals along with the specific services and activities necessary for the consumer to meet those goals and improve his or her capacity to function in the community. The treatment plan shall be developed in collaboration with the consumer or guardian when feasible. The consumer's participation in the development of the treatment plan shall be documented.

(b) Individual treatment team members shall ensure the consumer is actively involved in the development of treatment and service goals.

(c) The treatment plan shall clearly specify the services and activities necessary to meet the consumer's needs and who will be providing those services and activities.

(d) The following key areas shall be addressed in every consumer's treatment plan: symptom management, physical health issues, substance abuse, education and employment, social development and functioning, activities of daily living, and family structure and relationships.

(e) The primary case manager and the individual treatment team shall be responsible for reviewing and revising the treatment goals and plan whenever there is a major decision point in the consumer's course of treatment, e.g., significant change

in consumer's condition, etc., or at least every six (6) months a treatment plan review and every twelve (12) months a new comprehensive treatment plan will be developed. The revised treatment plan shall be based on the results of a treatment planning meeting. The plan and review will be signed by the consumer, the primary case manager, individual treatment team members, the team leader, the psychiatrist, and all other PACT team members.

(f) The PACT team shall maintain written assessment and treatment planning policies and procedures to assure that appropriate, comprehensive, and on-going assessment and treatment planning occur.

(g) Compliance with 450:55-5-7 shall be determined by review of the clinical records.

450:55-5-9. PACT progress note

(a) The PACT shall have a policy and procedure mandating the chronological documentation of progress notes. Every contact and service that relates to the consumer's treatment shall be documented.

(b) Progress notes shall minimally address the following:

- ~~(1) Person(s) who received services;~~
- ~~(2) Date and the start and stop time frame of the service provided;~~
- ~~(3) Staff travel times prior to and following the service, if applicable;~~
- ~~(4) Activities and services provided and as they relate to the goals and objectives of the treatment plan;~~
- ~~(5) Detailed description of the contact or service;~~
- ~~(6) The consumer's response to intervention services, changes in behavior and mood, and outcome of intervention services;~~
- ~~(7) Plans for continuing treatment;~~
- ~~(8) The location of the service provided; and~~
- ~~(9) Clinician's signature with credentials.~~
- (1) Date;
- (2) Person(s) to whom services were rendered;
- (3) Start and stop time for each timed treatment session or service;
- (4) Original signature of the therapist/service provider;
- (5) Credentials of therapist/service provider;
- (6) Specific treatment plan problems(s), goals and/or objectives addressed;
- (7) Services provided to address need(s), goals and/or objectives;
- (8) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;
- (9) Location of service;
- (10) 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?);
- (11) Any new need(s), goals and/or objectives identified during the session or service.

(c) Compliance with 450:55-5-9 shall be determined by a review of clinical records.

SUBCHAPTER 11. ORGANIZATIONAL MANAGEMENT

450:55-11-2. Program organization

(a) The parent organization under which the PACT operates shall vest authority with a team leader who shall be responsible for ensuring the PACT team meets the following organizational requirements.

(1) Each PACT shall have a written plan for professional services, which shall contain the following:

- (A) Services description and philosophy;
- (B) The identification of the professional staff organization to provide these services;
- (C) Written admission and exclusionary criteria to identify the type of consumers for whom the services are primarily intended;
- (D) The specific geographic area in which PACT services are to be provided;
- ~~(E) Written goals and objectives; and~~
- ~~(F) Delineation of processes to assure accessible, integrated, and co-occurring capable services and a plan for how each program component will address the needs of individuals with co-occurring disorders.~~

(2) There shall be a written statement of the procedures and plans for attaining the organization's goals and objectives. These procedures and plans should define specific tasks, including actions regarding the organization's co-occurring capability, set target dates and designate staff responsible for carrying out the procedures and plans.

(b) Compliance with 450:55-11-2 shall be determined by a review of the following: PACT target population definition, PACT policy and procedures, written plan for professional services, other stated required documentation and any other supporting documentation.

[OAR Docket #10-548; filed 4-8-10]

**TITLE 485. OKLAHOMA BOARD OF NURSING
CHAPTER 1. ADMINISTRATION**

[OAR Docket #10-584]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- 485:1-1-1. [AMENDED]
- 485:1-1-2. [AMENDED]
- 485:1-1-4. [AMENDED]
- 485:1-1-5. [AMENDED]

AUTHORITY:

Oklahoma Board of Nursing 59 O.S. §§567.2A.3, 567.4F, 567.5, 567.6, 567.8, 567.12, 567.15, and 567.17.

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ANALYSIS:

Revisions adopted in section 485:1-1-1. Functions, adds information regarding the budget approval and authorization for disbursement of funds.

The adopted revisions in section 485:1-1-2. Officers, aligns the duties of the Secretary to the current duties performed by the Secretary and clarifies that the three officers participate in the development of the budget.

Revisions adopted 485:1-1-4. Business meetings, includes changes to reflect the correct statute citation, the current statute language regarding special meetings and modifies time parameters for Board members to place a special topic on the Board's agenda.

Revisions adopted in section 485:1-1-5(b) and (c) allow the Board an opportunity to study the issues related to petitions prior to moving forward with the rule promulgation process or issuing a declaratory ruling determination.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. §308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2010:

485:1-1-1. Functions

The Board is authorized to:

- (1) *adopt and revise rules not inconsistent with . . . the Oklahoma Nursing Practice Act; [59 O.S. Section 567.4(F)]*
- (2) *prescribe standards for educational programs preparing persons for licensure to practice practical nursing, registered nursing, or preparing individuals for advanced practice nursing;*
- (3) *provide for surveys of such educational programs;*
- (4) *approve such educational programs for the preparation of practitioners of practical nursing, registered nursing, or advanced practice nursing as shall meet the requirements of this statute and of the Board;*
- (5) *deny, or withdraw approval of educational programs for failure to meet or maintain prescribed standards required by this statute and by the Board;*
- (6) *examine, license and renew the licenses of duly qualified applicants;*
- (7) *recognize Advanced Practitioners in accordance with the Rules and Regulations;*
- (8) *conduct hearings upon charges calling for disciplinary action; and*

(9) *provide consultation, conduct conferences, forums, studies and research on nursing education and practice.*

(10) approve the agency's budget and authorize disbursement of the funds by the Executive Director.

485:1-1-2. Officers

(a) **Election of officers.** The officers of the Board shall be elected annually at the regular meeting in January. The candidate receiving the plurality of votes shall be declared elected and shall assume office on the first day of March following their election.

(b) **Vacancies in office.**

(1) A vacancy occurring in the office of President shall be filled by the Vice-President for the unexpired term.

(2) A vacancy occurring in the office of Vice-President shall be filled by appointment by the President with the approval of the Board for the period of the unexpired term.

(3) A vacancy occurring in the office of the Secretary shall be filled by appointment by the President with the approval of the Board for the period of the unexpired term.

(c) **Duties of officers.**

(1) The President shall preside at meetings and shall appoint members to serve on such committees as may be created and shall be an ex-officio member of all committees. The President shall cause the agenda to be prepared for the meeting.

(2) The Vice-President shall preside in the absence of the President, and shall assume the duties of the President, when necessary.

(3) ~~The Secretary~~ Secretary/Treasurer shall cause to be completed the necessary arrangements for the meetings; send notices and agendas of the meetings to the members of the Board and the Secretary of State; record the minutes of the meeting; and conduct the necessary correspondence of the Board and keep a register of the names of all Licensed Practical Nurses and Registered Nurses duly licensed under the provisions of the Oklahoma Nursing Practice Act.

(4) ~~The Secretary, who is also the Treasurer, officers of the Board shall participate in the development of the budget and shall be responsible for the disbursement of the funds with the approval of the Board.~~

485:1-1-4. Business meetings

(a) **Special meetings.** *Special meetings may be called by the President or Secretary or petitioned by three (3) Board members with five (5) days notice to each member of the Board. [59 O.S. Section 567.4(EE)]*

(b) **Emergency meetings.** Emergency meetings may be called by the President without required notice for situations of imminent peril to the public health, safety, welfare or other compelling extraordinary circumstances.

(c) **Agenda.** A copy of the agenda shall be sent to each member at least five (5) days prior to the meeting. Any member wishing to have a special topic placed on the agenda shall notify the ~~Secretary~~ President at least ~~ten (10)~~ fifteen (15) days

prior to the meeting. Items of an emergency nature shall be considered at any meeting without prior notice.

(d) **Record of meeting.** The Secretary shall cause to be kept a record of all meetings which shall include a recording of votes by each member in attendance and such records shall be retained as a permanent record of the transaction of the Board.

(e) **Parliamentary authority.** The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the meetings in all instances to which they are applicable. The President shall have a vote on all matters coming before the Board.

(f) **Notice of meetings.** Notice of all meetings shall be in writing and delivered to Board members ten (10) days prior to meeting.

485:1-1-5. Rules and regulations

(a) **Adoption, amendment, or repeal of rules.** The adoption, amendments, filing, or repeal of rules will be in accordance with the Oklahoma Administrative Procedures Act.

(b) **Petition requesting promulgation, amendment or repeal of a rule.**

(1) ~~Any person Registered Nurse or Licensed Practical Nurse may petition the Board in writing requesting the promulgation, amendment, or repeal of a rule. The petition shall include the language of the requested rule, amendment or repeal, a statement of the purpose of the requested rule, amendment or repeal, at least one example of a fact situation to which the rule, amendment or repeal will apply, and the name and address of the person who requested the rule, amendment or repeal. If the requesting party is an association or corporate body, the petition shall identify a contact person at the association or corporate body who is able to provide meaningful information about the request. The petition shall be accompanied by an explanation and implications of the request and shall be:~~

- ~~(A) co-signed by at least ten (10) Registered Nurses or Licensed Practical Nurses;~~
- ~~(B) submitted to the Board at least thirty (30) days prior to a regular meeting;~~
- ~~(C) referred to the Board's attorney for legal consideration;~~
- ~~(D) considered by the Board at a regular meeting; and~~
- ~~(E) scheduled for a Public Hearing within ninety (90) days after being considered by the Board in a regular meeting~~

(2) A petition requesting promulgation, amendment or repeal of a rule shall not be considered by the Board if the subject of the Petition is the same as or similar to the subject presented in a Petition and considered by the Board within the previous twelve (12) months.

(3) The petition shall be cosigned by at least ten persons.

(4) The petition shall be submitted to the Board not less than forty five (45) days prior to a regular meeting.

(5) The Board, on its own motion or upon the request of any other interested party, may require any petitioner to provide additional information, as may be specified by the Board, for use in the Board's consideration and disposition of the petition. The failure of the petitioner to provide such information shall constitute grounds for the Board to take no further action on a petition.

(6) The Board shall refer the petition to its counsel for legal consideration. In addition, the Board may refer the petition to an appropriate advisory committee or subcommittee for review prior to the Board's action. The advisory committee or subcommittee review and recommendation shall not constitute Board action. Upon completion of the study period, the petition shall be referred to the Board with the recommendation of the committee, if any.

(7) If the Board determines the requested action or some other action should be taken, then notice of the proposed action shall be published in accord with the Administrative Procedures Act and the matter shall be set for public hearing. At the time and place designated for the public hearing, proponents and opponents of the proposed rulemaking action may be heard in the manner and order prescribed by the Board at that time.

(8) At the Board meeting during which the public hearing is held or immediately thereafter the Board shall render its decision on the petition and shall take such action as it deems necessary and appropriate and as authorized by the Administrative Procedures Act to implement its decision.

~~(e) **Validity or applicability of rules — declaratory judgment.**~~

~~(1) Any person may request a declaratory ruling as to the applicability of any rule or order of the Board by filing a petition requesting such declaratory ruling which:~~

- ~~(A) is signed by the person making the request; and~~
- ~~(B) contains a concise statement of the facts and law supporting the request for action by the Board.~~

~~(2) The petition shall be promptly set for hearing by the Board at which hearing the Board shall consider all information relevant to the petition including argument of counsel. The declaratory ruling or the refusal to issue such ruling shall be ordered by the Board on or before the next scheduled meeting of the Board following the hearing.~~

~~(c) **Declaratory Rulings.**~~

(1) Any person or group may petition the Board for a declaratory ruling as to the applicability of any rule or order of the Board and any other person or group may file a response.

(2) A petition for declaratory ruling shall be signed by the person or association making the request and shall include a concise statement of the facts and the law supporting the request.

(3) The Board may request the petitioner or any respondent to submit any information it deems pertinent to the inquiry or useful in resolving the issue, including oral and documentary evidence and citations of legal authority.

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(4) The agency shall refer the petition to its counsel. The Board may refer the petition to an appropriate advisory committee or subcommittee for its review and a recommendation. The advisory committee or subcommittee may hold a hearing, take testimony of witnesses, require submission of legal memoranda, and hear argument of counsel just as the Board can do. The findings or recommendations of the advisory committee or subcommittee shall not constitute Board action. Upon completion of the period of study, whether the assigned committee held a hearing or not, the petition shall be referred to the Board with the recommendation of the committee.

(5) Upon receipt of the committee's recommendation in the Board office, Board staff shall have not less than thirty (30) days in which to disseminate the recommendation to the Board members so that it can be addressed at the next regularly scheduled Board meeting.

(6) The declaratory ruling or the refusal to issue such a ruling shall be ordered by the Board on or before the next scheduled meeting of the Board following completion of the period of study and referral of the petition back to the full Board for action.

(7) The agency shall give reasonable notice to the petitioner and any respondents to the petition in advance of the Board making a final ruling and the Board shall accompany any ruling with written findings of fact and conclusions of law.

[OAR Docket #10-584; filed 4-9-10]

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

[OAR Docket #10-585]

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RULES:

Subchapter 1. General Provisions
485:10-1-2. [AMENDED]
Subchapter 5. Minimum Standards for Approved Nursing Education Programs
485:10-5-8. [AMENDED]
Subchapter 7. Requirements for Registration and Licensure as a Registered Nurse
485:10-7-2. [AMENDED]
Subchapter 9. Requirements for Registration and Licensure as a Licensed Practical Nurse
485:10-9-2. [AMENDED]
Subchapter 10. Advanced Unlicensed Assistive Personnel
485:10-10-8. [AMENDED]
485:10-10-8.1. [AMENDED]
Subchapter 11. Disciplinary Action
485:10-11-2. [AMENDED]
Subchapter 13. Requirements for Employment
485:10-13-1. [AMENDED]
Subchapter 19. Peer Assistance Program
485:10-19-4. [AMENDED]
485:10-19-5. [AMENDED]
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ANALYSIS:

In Chapter 10, a definition was adopted for "innovative approach" in section 485:10-1-2. This definition supports rules that were adopted for section 485:10-5-8 to describe the process by which a nursing education program may request approval to implement a learning model that departs from current rule structure.

Revisions adopted for sections 485:10-7-2 and 485:10-9-2 provide for an additional type of certificate program offered by the Commission on Graduates of Foreign Nursing Schools to be used by applicants for licensure by endorsement as a foreign educated nurse. In addition, clarification is provided to rules on issuance of temporary licenses.

In sections 485:10-10-8 and 485:10-10-8.1, requirements for recertification and reinstatement of certification as an advanced unlicensed assistive person were adopted to allow the Board to implement an online recertification and reinstatement process.

In Subchapter 11, clarifying language was adopted in 485:10-11-2 to allow the Board's legal advisor to rule on admissibility of evidence, objections to evidence, and other motions during Board hearings.

In Subchapter 13, a provision was adopted to refer the nurse who holds educational credentials that allow for the use of the term "doctor" to statutes that address this practice. In addition, grammatical changes were adopted.

The adopted revisions to 485:10-19-4 clarifies licensure or certification requirements related to membership of at least one of the Peer Assistance Committee members to reflect the statute changes related to regulation of individuals who provide alcohol and drug counseling in Oklahoma. In addition, a quorum of the Peer Assistance Committee is identified.

The adopted revisions to 485:10-19-5 clarifies applicant qualifications. The requirement for an unrestricted license is deleted as nurses referred by the Board have conditional licensure status. The requirement for residing in the state was deleted with the addition of practicing only in the State of Oklahoma while participating in the program. The revision allows participation of applicants who are licensed in Oklahoma and reside in border states.

The adopted revisions to 485:10-19-8 further clarify terminations from the program.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. §308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

485:10-1-2. Definitions

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

"**Accountable**" means assuming responsibility to the client, the public, other health-care practitioners and oneself for one's actions and/or decisions and their outcomes.

"**Additional nursing function**" means the nursing functions, procedures, or tasks, not usually included at the time of matriculation in most nursing education programs; requiring additional knowledge, instruction, and practice before they can be safely performed. Such functions must fall within the scope of accepted nursing practice; may become necessary due to technological advances, new practice standards, or the natural evolution of an occupation; and must not be precluded by other Oklahoma Practice Acts.

"**Advanced practice nurse**" is a term that includes Advanced Registered Nurse Practitioners (ARNP), Clinical Nurse Specialists (CNS), Certified Nurse Midwives (CNM), and Certified Registered Nurse Anesthetists (CRNA).

"**Advanced unlicensed assistive person**" means an individual, other than a licensed nurse, who performs in an assistive role and has been certified to perform core skills as delegated by a licensed nurse and as authorized by the Rules and Regulations of the Oklahoma Board of Nursing.

"**Board**" means the Oklahoma Board of Nursing [59 O.S. Section 567.3(1)]

"**Client**" means a consumer of nursing care; may be an individual or group; is synonymous with "patient".

"**Clinical learning experiences**" means faculty-planned and guided activities designed to assist students to meet stated program and course outcomes and to safely apply knowledge and skills when providing nursing care to clients across the lifespan as appropriate to the role expectations of the graduates. These experiences occur in a variety of affiliating agencies or clinical practice settings including, but not limited to: acute care facilities, extended care facilities, long-term care facilities, clients' residences, and community agencies; and in associated clinical pre- and post-conferences.

"**Clinical skills laboratory**" means a designated area in which equipment and supplies are provided to simulate a clinical facility, allowing skills and procedures to be demonstrated and practiced.

"**Controlling institution**" means the agency or institution that administers the nursing education program, assumes responsibility for its financing, graduates the students, and grants the diploma, certificate or degree to the graduates.

"**Core skills**" means the list of functions developed by the working committee prescribed in 59 O.S. § 567.3a.13 that an advanced unlicensed assistive person shall be able to perform upon completion of the certification training program and satisfactory passage of the certification examination.

"**Delegating**" means entrusting the performance of selected nursing duties to individuals qualified, competent and legally able to perform such duties.

"**Distance learning program**" means 50% or more of the theory components of the board-approved nursing education program are offered by correspondence, on-line, through video-conferencing, or via CD-ROM.

"**Innovative approach**" means a creative nursing education strategy that departs from the current rule structure and requires Board approval for implementation.

"**Legal authority**" means the authorized state agency for the administration of the statutes relating to the practice of nursing in this state. The Oklahoma Board of Nursing is the only legal authority for licensing practical nurses, Registered Nurses, and issuing recognition to advanced practice nurses in Oklahoma.

"**Licensed nurse**" means a registered nurse or licensed practical nurse, currently licensed by the Oklahoma Board of Nursing.

"**Nurse Administrator**" means the Registered Nurse responsible for the administration of the nursing education program or the nurse holding the highest level of management in an agency/facility regardless of the title used.

"**Preceptor**" means a licensed nurse who is employed by the facility in which the clinical experience takes place, and who agrees to provide supervision to a student for a specified period of time during the preceptor's scheduled work hours in order to assist the student to meet identified learning objectives.

"**State approved program of nursing**" means a nursing education program approved by the Oklahoma Board of Nursing.

"**Member board jurisdiction**" means a full member board of National Council of State Boards of Nursing.

"**Supervising**" means providing guidance by a qualified nurse for the accomplishment of the nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing a task or activity.

SUBCHAPTER 5. MINIMUM STANDARDS FOR APPROVED NURSING EDUCATION PROGRAMS

485:10-5-8. Experimentation

A nursing education program which wishes to initiate an experimental program or innovative approach shall apply to the Board in writing for the approval of its plan. Nursing education programs approved to implement innovative approaches shall continue to provide quality nursing education that prepares graduates to practice safely, competently, and ethically within the scope of practice as defined in Oklahoma's statutes.

(1) Purposes

(A) To foster innovative models of nursing education to address the changing needs in health care.

(B) To assure that innovative approaches are conducted in a manner consistent with the Board's role of protecting the public.

(C) To assure that innovative approaches conform to the quality outcome standards and core education criteria established by the Board.

(2) Eligibility

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- (A) The nursing education program shall hold full Board approval with no warnings with unmet conditions or survey visit recommendations that are unmet.
- (B) There are no substantiated complaints in the past 2 years.
- (C) There are no rule violations in the past 2 years.
- (3) Application. The following information shall be provided to the Board at least one month prior to a Board meeting:
 - (A) Identifying information (name of nursing program, address, responsible party and contact information).
 - (B) A brief description of the current program, including accreditation and Board approval status.
 - (C) Identification of the regulation(s) affected by the proposed innovative approach.
 - (D) Length of time for which the innovative approach is requested.
 - (E) Description of the innovative approach, including objective(s).
 - (F) Explanation of how the proposed innovation differs from approaches in the current program.
 - (G) Rationale with available evidence supporting the innovative approach.
 - (H) Identification of resources that support the proposed innovative approach.
 - (I) Expected impact innovative approach will have on the program, including administration, students, faculty, and other program resources.
 - (J) Plan for implementation, including timeline.
 - (K) Plan for evaluation of the proposed innovation, including measurable criteria/outcomes, method of evaluation, and frequency of evaluation.
 - (L) Additional application information as requested by the Board.
- (4) Standards for approval
 - (A) Eligibility criteria in (2) and application criteria in (3) are met.
 - (B) The innovative approach will not compromise the quality of education or safe practice of students.
 - (C) Resources are sufficient to support the innovative approach.
 - (D) Rationale with available evidence supports the implementation of the innovative approach.
 - (E) Implementation plan is reasonable to achieve the desired outcomes of the innovative approach.
 - (F) Timeline provides for a sufficient period to implement and evaluate the innovative approach.
 - (G) Plan for periodic evaluation is comprehensive and supported by appropriate methodology.
- (5) Review of application and board action
 - (A) Annually the Board may establish the number of innovative approach applications it will accept, based on available Board resources.
 - (B) The Board shall evaluate all applications to determine if they meet the eligibility criteria in (2) and the standards established in (3).
 - (C) Based on its evaluation, the Board may:
 - (i) Approve the application; or
 - (ii) Approve the application with modifications as agreed between the Board and the nursing education program; or
 - (iii) Defer a decision on the application pending receipt of additional information; or
 - (iv) Deny the application.
- (6) The Board may rescind the approval or require the program to make modifications if:
 - (A) The Board receives substantiated evidence indicating adverse impact.
 - (B) The nursing education program fails to implement the innovative approach as presented and approved.
 - (C) The nursing education program has a change in its approval status, its ownership status or administrative structure, or its faculty, such as would significantly impact its ability to implement the innovative approach.
- (7) Periodic Evaluation
 - (A) The education program shall submit progress reports conforming to the evaluation plan annually or as requested by the Board.
 - (B) The final evaluation report shall conform to the evaluation plan, detailing and analyzing the outcomes data.
 - (C) If any report indicates that students were adversely impacted by the innovation, the nursing program shall provide documentation of corrective measures and their effectiveness.
- (8) Requesting continuation of the innovative approach. If the innovative approach has achieved the desired outcomes and the final evaluation has been submitted, the Board may consider a change in the rules that would provide for implementation of the innovative approach by nursing education programs.

SUBCHAPTER 7. REQUIREMENTS FOR REGISTRATION AND LICENSURE AS A REGISTERED NURSE

485:10-7-2. Licensure by endorsement

- (a) **Qualifications.**
 - (1) The applicant must submit an application containing such information as the Board may prescribe.
 - (2) An applicant for licensure by endorsement as a Registered Nurse must meet the requirements of the Oklahoma Nursing Practice Act. An evaluation of educational requirements may be completed to ensure the applicant meets educational standards.
 - (3) An applicant licensed in another state or U.S. territory since January 1, 1952 must have written the licensing examination adopted by the Board with a passing score as established by the Board. A license to practice nursing in Oklahoma will not be issued until this requirement is met.
 - (4) An applicant must submit evidence of either:

- (A) successful completion of the National Council Licensure Examination for Registered Nurses since July 1, 1982; or
 - (B) passing the State Board Test Pool Examination for Registered Nurse licensure prior to July 1, 1982.
- (5) In addition to meeting other requirements for endorsement established by the Board in these rules, effective January 1, 2005, each applicant for endorsement must demonstrate evidence of continued qualifications for practice through completion of one or more of the following requirements within the last two (2) years prior to receipt of the completed application in the Board office:
- (A) Submission of an official transcript or certificate of completion verifying completion of a nurse refresher course with content consistent with Board policy;
 - (B) Successfully pass the National Council Licensure Examination for Registered Nurses;
 - (C) Submission of an official transcript verifying successful completion of at least seven (7) academic semester credit hours of nursing courses which include classroom and clinical instruction; and/or
 - (D) Present evidence of licensure as a registered nurse in another state with employment in a position that requires nursing licensure with verification of at least 520 work hours during the past two (2) years.
- (6) Applicants for endorsement who took the National Council Licensure Examination for Registered Nurses for initial licensure within the last two years must:
- (A) Provide evidence of completion of the nursing education program within two years of initial application for licensure by examination; or
 - (B) Provide evidence of at least six months work experience as a registered nurse in the state, U.S. territory, or country of original licensure.
- (b) **Applications.**
- (1) Applications must be completed, notarized and accompanied by a photograph signed by the applicant and filed with the Board.
 - (2) Endorsement may be accepted from the original state or U.S. territory of licensure by examination.
 - (3) If the applicant has written the licensing examination adopted by the Board in a state other than the state or U.S. territory of original licensure, an endorsement will be requested from that state, also.
 - (4) If the application is not completed within one (1) year after receipt of fee, the application must be refilled.
- (c) **Fee for licensure by endorsement.**
- (1) The fee shall accompany the application.
 - (2) The fee is not refundable.
 - (3) If the application is not completed within one (1) year, a new application and new fee will be required for licensure.
- (d) **Qualifications for applicants educated in foreign countries or in a U. S. territory.** An applicant educated in a foreign country must meet the current educational requirements for licensure in Oklahoma. An applicant educated in a U.S. territory not recognized as a full member of National

Council of State Boards of Nursing (NCSBN) must meet the requirements for applicants educated in foreign countries. An applicant educated in a U.S. territory that is a full member of NCSBN but in a nursing education program not included on the NCSBN state-approved programs of nursing list at the time of the applicant's graduation from the program must meet the requirements for applicants educated in foreign countries.

- (1) The applicant must present evidence of:
 - (A) graduation from a government-approved nursing education program, as verified from the Commission of Graduates of Foreign Nursing Schools (CGFNS);
 - (B) completion of formal courses including theory and clinical experience in nursing care of the adult, nursing care of children, maternal-infant nursing, psychiatric-mental health nursing as evidenced by:
 - (i) a translated transcript with certified proof of translation received directly from the nursing education program in the original country of licensure, or
 - (ii) a certified copy of original transcript obtained directly from the Commission of Graduates of Foreign Nursing Schools (CGFNS)
 - (C) licensure in country of graduation as evidenced by official verification received directly from the Commission of Graduates of Foreign Nursing Schools;
 - (D) current competence in oral and written English as evidenced by receipt of current, valid scores directly from the approved testing service verifying successful completion of:
 - (i) Test of English as a Foreign Language (TOEFL) and Test of Spoken English (TSE) and Test of Written English (TWE) of the Educational Testing Service, or
 - (ii) Test of English for International Communication (TOEIC) and Test of Spoken English and Test of Written English of the Educational Testing Service, or
 - (iii) International English Language Testing System (IELTS), or
 - (iv) Test of English as a Foreign Language Internet-based test (TOEFL iBT) of the Educational Testing Service.
 - (E) An evaluation of educational credentials as evidenced by:
 - (i) CGFNS Certificate Status or Visa Screen Certificate or
 - (ii) CGFNS Healthcare Profession and Science Course-by-Course Report;
 - (iii) Reports received from CGFNS must have been completed within the five (5) years immediately preceding the date of application for licensure by endorsement. The five-year requirement is waived if the applicant holds a license in another state.
 - (F) Evidence of either:

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- (i) successful completion of the National Council Licensure Examination for Registered Nurses since July 1, 1982; or
 - (ii) passing the State Board Test Pool Examination for Registered Nurse licensure prior to July 1, 1981;
- (2) The requirements for competence in spoken and written English are waived for applicants who are:
- (A) Graduates of nursing education programs taught in English in Australia, Canada (except Quebec), Ireland, New Zealand, the United Kingdom, Trinidad, Tobago, Jamaica, Barbados, South Africa, and the United States.
 - (B) Licensed in another US State or Territory, have successfully completed the licensure examination approved by the Board and provide evidence of at least one year full-time equivalent work experience in a clinical setting as a registered nurse in the state of licensure.
 - (3) Applicants must submit a completed application and the required fee.
- (e) **Temporary license for endorsement applicants.**
- (1) A temporary license may be issued to the applicant on proof of
 - (A) Current unrestricted licensure in another state with no history of arrest or disciplinary action requiring further review;
 - (B) Evidence of having successfully passed the licensure examination adopted by the Oklahoma Board of Nursing;
 - (C) Evidence of meeting educational qualifications through completion of a state board-approved nursing education program meeting the educational standards established by the Board, or an evaluation of educational credentials and nursing licensure in country of origin for the foreign-educated nurse as evidenced by:
 - (i) Commission on Graduates of Foreign Nursing Schools (CGFNS) Healthcare Profession and Science Course-by-Course Report with verification of equivalent educational credentials and unrestricted licensure in country of origin, or
 - (ii) Commission on Graduates of Foreign Nursing Schools (CGFNS) Certificate status or Visa Screen Certificate, accompanied by a verification of graduation from a government approved nursing education program, the translated transcript, and verification of unrestricted nursing licensure in country of graduation;
 - (D) Payment of the fee for licensure by endorsement and temporary license; ~~and~~
 - (E) Foreign-educated applicants must provide evidence of current competence in oral and written English by meeting the requirements of 485:10-7-2(d)(1)(D)(i-iv); and
 - (F) Certification of employment in a position that requires nursing licensure as a registered nurse for a minimum of 520 work hours in the past two years.

- (2) The temporary license may not be issued for a period longer than ninety (90) days.
- (3) The temporary license may be extended, but such period shall be no longer than one (1) year for any applicant.

SUBCHAPTER 9. REQUIREMENTS FOR REGISTRATION AND LICENSURE AS A LICENSED PRACTICAL NURSE

485:10-9-2. Licensure by endorsement

- (a) **Qualifications.**
- (1) The applicant must submit an application containing such information as the Board may prescribe.
 - (2) An applicant for licensure by endorsement as a Licensed Practical Nurse shall meet the requirements of the Oklahoma Nursing Practice Act. An evaluation of educational requirements may be completed to ensure the applicant meets educational standards.
 - (3) An applicant licensed in another state or U.S. territory since June 30, 1954 must have passed the licensing examination adopted by the Board. A license to practice practical nursing in Oklahoma will not be issued until this requirement is met.
 - (4) In addition to meeting other requirements for endorsement established by the Board in these rules, effective January 1, 2005, each applicant for endorsement must demonstrate evidence of continued qualifications for practice through completion of one or more of the following requirements within the last two (2) years prior to receipt of the completed application in the Board office:
 - (A) Submission of an official transcript or certificate of completion verifying completion of a nurse refresher course with content consistent with Board policy;
 - (B) Successfully pass the National Council Licensure Examination for Practical Nurses;
 - (C) Submission of an official transcript verifying successful completion of at least seven (7) academic semester credit hours or 105 contact hours of nursing courses in a state-approved practical or registered nursing education program, which includes classroom and clinical instruction; and/or
 - (D) Present evidence of licensure as a practical nurse in another state with employment in a position that requires practical nursing licensure with verification of at least 520 work hours during the past two (2) years.
 - (5) Applicants for endorsement who took the National Council Licensure Examination for Practical Nurses for initial licensure within the last two years must
 - (A) Provide evidence of completion of the nursing education program within two years of initial application for licensure by examination; or
 - (B) Provide evidence of at least six months work experience as a practical nurse in the state, U.S. territory, or country of original licensure.

(b) **Applications.**

- (1) Applications must be completed, certified and accompanied by a photograph signed by the applicant and filed with the Board.
- (2) Endorsement may be accepted from the original state of licensure by examination.
- (3) If the applicant has written the licensing examination adopted by the Board in a state other than the state or U.S. territory of original licensure, an endorsement will be requested from that state, also.
- (4) If the application is not completed within one (1) year after receipt of fee, the application must be refilled.

(c) **Fee for licensure by endorsement.**

- (1) The fee shall accompany the application.
- (2) The fee is not refundable.
- (3) If the application is not completed within one (1) year, a new application and new fee will be required for licensure.

(d) **Qualifications for applicants educated in foreign countries or in a U. S. territory.** An applicant educated in a foreign country must meet the current educational requirements for licensure in Oklahoma. An applicant educated in a U.S. territory not recognized as a full member of National Council of State Boards of Nursing (NCSBN) must meet the requirements for applicants educated in foreign countries. An applicant educated in a U.S. territory that is a full member of NCSBN but in a nursing education program not included on the NCSBN state-approved programs of nursing list at the time of the applicant's graduation from the program must meet the requirements for applicants educated in foreign countries.

- (1) The applicant must present evidence of:
 - (A) completion of a high school diploma or high school equivalency certificate (GED), or meet criteria for an Adult High School Diploma;
 - (B) current competence in oral and written English as evidenced by receipt of current, valid scores directly from the testing service verifying successful completion of:
 - (i) Test of English as a Foreign Language (TOEFL), Test of Written English (TWE), and Test of Spoken English (TSE) of the Educational Testing Service; or
 - (ii) Test of English for International Communication (TOEIC) and Test of Spoken English and Test of Written English of the Educational Testing Service; or
 - (iii) International English Language Testing System (IELTS); or
 - (iv) Test of English as a Foreign Language Internet-based test (TOEFL iBT) of the Educational Testing Service.
 - (C) graduation from a government approved practical nursing education program or equivalent courses in a government approved nursing education program, as verified from the Commission of Graduates of Foreign Nursing Schools (CGFNS);
 - (D) licensure in country of graduation as evidenced by official verification completed within the last 12

months immediately preceding the date of application for licensure by endorsement received directly from the Commission of Graduates of Foreign Nursing Schools,

(E) completion of formal courses including theory and clinical experience in nursing care of the adult, nursing care of children, and maternal-infant nursing in a government-approved school of nursing as evidenced by:

- (i) a translated transcript received directly from the nursing education program in the original country of licensure with certified proof of translation; or
- (ii) a certified copy of the transcript received directly from the Commission on Graduates of Foreign Nursing Schools (CGFNS).

(F) An evaluation of educational credentials as evidenced by:

- (i) Commission on Graduates of Foreign Nursing Schools (CGFNS) Healthcare Profession and Science Course-by-Course Report or
- (ii) Commission on Graduates of Foreign Nursing Schools (CGFNS) Certificate or Visa Screen Certificate status;
- (iii) Reports received from CGFNS must have been completed within the five (5) years immediately preceding the date of application for licensure by endorsement. The five-year requirement is waived if the applicant holds a license in another state.

(2) The applicant must successfully complete the licensing examination adopted by the Oklahoma Board of Nursing.

(3) The requirements for competence in spoken and written English are waived for applicants who are:

- (A) Graduates of nursing education programs taught in English in Australia, Canada (except Quebec), Ireland, New Zealand, the United Kingdom, Trinidad, Tobago, Jamaica, Barbados, South Africa, and the United States or
- (B) Licensed in another US State or Territory, have successfully completed the licensure examination approved by the Board and provide evidence of at least one year full-time equivalent work experience in a clinical setting as a practical nurse in the state of licensure.

(4) Applicants must submit a completed application with the required application and evaluation fees.

(e) **Temporary license for endorsement applicants.**

(1) A temporary license may be issued to the applicant on proof of

(A) Current unrestricted licensure in another state with no history of arrest or disciplinary action requiring further review;

(B) Evidence of having successfully passed the licensure examination adopted by the Oklahoma Board of Nursing;

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(C) Evidence of meeting educational qualifications through completion of a state board-approved nursing education program meeting the educational standards established by the Board, or an evaluation of educational credentials and nursing licensure in country of origin for the foreign-educated nurse as evidenced by:

(i) Commission on Graduates of Foreign Nursing Schools (CGFNS) Healthcare Profession and Science Course-by-Course Report with verification of equivalent educational credentials and unrestricted licensure in country of origin, or

(ii) Commission on Graduates of Foreign Nursing Schools (CGFNS) Certificate status or Visa Screen Certificate, accompanied by a verification of graduation from a government approved nursing education program, the translated transcript, and verification of unrestricted nursing licensure in country of graduation;

(D) Payment of the fee for licensure by endorsement and temporary license; ~~and~~

(E) Foreign-educated applicants must provide evidence of current competence in oral and written English by meeting the requirements of 485:10-9-2(d)(1)(B)(i-iv); ~~and~~

(F) Certification of employment in a position that requires nursing licensure as a licensed practical nurse for a minimum of 520 work hours in the past two years.

(2) The temporary license may not be issued for a period longer than ninety (90) days.

(3) The temporary license may be extended, but such period shall be no longer than one (1) year for any applicant.

SUBCHAPTER 10. ADVANCED UNLICENSED ASSISTIVE PERSONNEL

485:10-10-8. Recertification

(a) Certification as an advanced unlicensed assistive person shall be renewed every two years in accordance with the schedule published by the Board.

(b) The application for recertification must be completed and accompanied by the established fee before a new certificate is issued.

(c) The applicant must submit an application containing such information as the Board may prescribe.

(d) The application for recertification must be accompanied by one of the following:

(1) ~~notarized~~ verification of employment as an AUA in an acute care setting for a minimum of 12 months within the previous 24 months immediately prior to renewal of AUA certification; or

(2) ~~documentation verifying~~ verification of successful completion of twelve hours of clinical inservice appropriate to the AUA role within the previous 24 months; or

(3) rewriting the certification examination with a passing score, both the written and core skills portions of

the exam, within the 24 months immediately preceding renewal of AUA certification; or

(4) ~~documentation verifying~~ verification of initial certification as an AUA within the 24 months immediately prior to renewal of AUA certification.

(e) The fee for renewal of the certificate shall be established by the Board.

485:10-10-8.1. Reinstatement of certification

(a) The certification of the advanced unlicensed assistive person is lapsed if not renewed by expiration date thereof.

(b) A completed application for reinstatement must be submitted to the Board office with the required fee. If the application is not completed within one (1) year, a new application and new fee will be required.

(c) The applicant must submit an application containing such information as the Board may prescribe.

(d) The application for reinstatement must be accompanied by one of the following:

(1) ~~notarized~~ verification of employment as an AUA in an acute care setting for a minimum of 12 months within the previous 24 months; or

(2) ~~documentation verifying~~ verification of successful completion of twelve hours of clinical inservice appropriate to the AUA role within the previous 24 months; or

(3) rewriting the certification examination with a passing score, both the written and core skills portions of the exam; or

(4) ~~documentation verifying~~ verification of initial certification as an AUA within the 24 months immediately prior to reinstatement of AUA certification.

(e) An application for reinstatement for a certification that has been revoked, suspended or surrendered must be in compliance with all terms and conditions of any Order entered with regard to the revocation, suspension or surrender and shall be considered by the Board.

SUBCHAPTER 11. DISCIPLINARY ACTION

485:10-11-2. Hearings

(a) **Conduct of hearing.** All hearings and notice thereof shall be conducted and governed in accordance with the provisions of the Oklahoma Administrative Procedures Act. [75 O.S. Section 309]

(b) **Notice of hearing.** Notice of the hearing shall be served in any manner authorized by the Oklahoma Pleading Code for the personal service of summons in proceedings in state courts.

(c) **Procedures before the Board.**

(1) Every individual proceeding shall be initiated by a sworn complaint containing a brief statement of the facts supporting the request for action by the Board.

(2) The respondent shall file with the Board a written response under oath to the complaint by the date to be furnished. If no response is filed, the respondent shall be considered in default and the Board may take whatever action it deems sufficient and appropriate. The Executive

Director of the Board or designee may extend the time within which a response must be filed, but in no event may the time be extended beyond the hearing date.

(3) Requests for continuances or extensions of time shall be filed in writing and state the reasons for the request and time desired. The Board or its designee shall promptly rule on such requests.

(4) Discovery shall be conducted in accordance with the Oklahoma Discovery Code except that all discovery must be completed prior to the date set for hearing unless otherwise ordered by the Board. The time periods contained in the Oklahoma Discovery Code shall be modified to conform to this Rule.

(5) The order of procedure shall be the same as followed by the state trial courts in civil proceedings.

(6) The admissibility of evidence shall be governed by the provisions of the Oklahoma Administrative Procedures Act [75 O.S. Section 310].

(7) The President of the Board or his/her designee shall rule on admissibility of evidence and objections to such evidence and shall rule on other motions or objections in the course of the hearing.

(8) The Board, its designee, attorney for the Board, the respondent or attorney for the respondent, may conduct examinations.

(9) A respondent who fails to appear, after having received proper notice, may be determined to have waived the right to present a defense to the charges in the complaint and the Board may declare the respondent in default and revoke, suspend or otherwise discipline respondent as it may deem necessary.

(10) Subpoenas for the attendance of witnesses and/or furnishing of information required by the Board and as requested by the respondent, and/or the production of evidence or records of any kind shall be issued by the Board. Should any person fail to obey a subpoena, the Board may institute appropriate judicial proceedings under the laws of the State for an Order to compel compliance with the subpoena.

(11) The respondent is responsible for any expenses associated with witnesses, subpoenas and/or evidence presented on her/his behalf.

(12) In the event disciplinary action is imposed against the defendant of an individual proceeding, the Board may require the defendant to reimburse the Board for its actual costs in the investigation and prosecution of the disciplinary action. Such costs shall include, but not be limited to: staff time and expenses, travel expenses, witness fees and expenses, attorney fees and expenses, and court reporter fees, if applicable.

(13) The respondent shall not communicate with any member of the Board concerning the matters alleged in the complaint before or during or after the hearing. This restriction does not apply to the presentation of testimony or evidence by the respondent in the course of the hearing.

(d) **Penalties.** When determining the amount of penalty to be imposed for a violation of the Oklahoma Nursing Practice Act the following additional factors shall be a part of

the consideration by the Board when establishing the nature, circumstance, and gravity of the violation, the degree of culpability, the effect on the ability of the person to continue to practice and any show of good faith in attempting to achieve compliance with the provisions of the Oklahoma Nursing Practice Act:

(1) evidence of actual or potential harm to patients, clients or the public;

(2) the seriousness of the violation, including the nature, circumstances, extent and gravity of any prohibited acts, and the hazard or potential hazard created to the health, safety and welfare of the public;

(3) evidence of misrepresentation(s) of knowledge, education, experience, credentials or skills which would lead a member of the public, an employer, a member of the health-care team, or a patient to rely on the fact(s) misrepresented where such reliance could be unsafe;

(4) evidence of practice history;

(5) evidence of present lack of fitness;

(6) evidence of prior disciplinary history by the Board or any other health care licensing agency in Oklahoma or another jurisdiction;

(7) the length of time the licensee has practiced;

(8) the actual damages, physical or otherwise resulting from the violation;

(9) the deterrent effect of the penalty imposed;

(10) attempts by the licensee to correct or stop the violation;

(11) any mitigating or aggravating circumstances;

(12) the extent to which system dynamics in the practice setting contributed to the problem;

(13) evidence of a lack of truthfulness or trustworthiness;

(14) any other matter that justice may require.

(e) **Orders.**

(1) At the conclusion of the hearing the Board will announce its decision and a written order will be issued within twenty (20) days of the Board's decision.

(2) A copy of the order shall be delivered or mailed to the respondent and the respondent's attorney of record.

(f) **Record of hearing.**

(1) The record in an individual proceeding shall be as defined in the Oklahoma Administrative Procedures Act and shall also include the licensing history of the respondent.

(2) All hearings shall be transcribed by a duly certified reporter, unless the presiding officer designates otherwise. A transcript of the proceedings shall not be made except in the event of an appeal of the decision of the Board, or upon written application accompanied by a deposit sufficient to cover the cost of transcription. Tapes and shorthand or stenotype notes of the proceedings shall be retained for a period of not less than five (5) years.

(g) **Appeals and reconsideration.** Requests for reconsideration and appeals of order in individual proceeding shall be in accordance with the Oklahoma Administrative Procedures Act.

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SUBCHAPTER 13. REQUIREMENTS FOR EMPLOYMENT

485:10-13-1. Conditions of employment

- (a) Any person who practices or offers to practice nursing or represents himself or herself themselves as a licensed nurse, (excluding federal employment) shall possess a valid Oklahoma license.
- (b) Any individual offering to practice advanced practice nursing as an ARNP, CNS, CNM, CRNA, shall possess a valid Oklahoma license and a certificate of recognition issued by the Board.
- (c) A valid temporary license shall be required in lieu of a full certificate of licensure.
- (d) Any person employed as a Nurse Administrator, as defined in these rules, shall possess a valid license to practice nursing in Oklahoma, except as otherwise provided by law.
- (e) If the term "doctor" is used by a licensed nurse holding the appropriate educational credentials, such usage must be in accordance with 59 O.S. Supp. 2009, §725.1, et seq.

SUBCHAPTER 19. PEER ASSISTANCE PROGRAM

485:10-19-4. Peer Assistance Committee(s)

- (a) Members of the Peer Assistance Committee(s) shall have expertise in chemical dependency.
- (b) Composition of the Committee shall be:
 - (1) at least three members,
 - (2) at least one member who is currently certified through the Addictions Nursing Certification Board, ~~the National Association of Alcohol and Drug Abuse Counselor Certification Board or the Oklahoma Drug and Alcohol Professional Counselor Certification Board~~ and/or licensed or certified by the Oklahoma Board of Licensed Alcohol and Drug Counselors,
 - (3) at least one recovering person, and
 - (4) the majority to be currently licensed nurses.
 - (5) A quorum shall be at least two members, with at least one member having expertise in chemical dependency.
- (c) The committee shall have the following responsibilities:
 - (1) determine licensee's acceptance into program,
 - (2) develop with licensee a contract for program participation,
 - (3) meet with licensee on a specified basis to monitor and determine progress,
 - (4) determine successful completion of program,
 - (5) determine termination from program for failure to comply,
 - (6) report all terminations to the Board.
- (d) The Peer Assistance Committee(s) shall be appointed by the Board from applications for a term of three years.

485:10-19-5. Qualifications of applicant

- (a) To be eligible for participation in the Peer Assistance Program, each applicant must:
 - (1) have a current ~~unrestricted~~ license to practice nursing in the State of Oklahoma, unless referred by the Board,
 - (2) have no pending felony charge or conviction that would prevent the nurse from practicing,
 - (3) voluntarily submit an application for participation, and
 - (4) ~~reside in this state~~ practice nursing only within the State of Oklahoma while participating in the Program.
- (b) Nurses previously disciplined by the Board shall be ineligible, unless referred to the Peer Assistance Program by the Board.
- (c) Nurses referred by the Board shall have sixty (60) days from the date of acceptance into the Program within which to obtain a current license.

485:10-19-8. Termination from program

- (a) The Peer Assistance Committee shall make the determination that a licensee has failed to comply with the contract and/or amended contracts ~~and~~ and/or treatment plan plan(s). A licensee may be terminated for any of the following reasons, including but not limited to:
 - (1) the licensee fails to comply with terms of the contract and/or amended contracts with the Peer Assistance Committee,
 - (2) the licensee has become unsafe to practice with reasonable skill and safety to patients under his care, or
 - (3) the licensee transfers to another state and fails to submit to that state's Board of Nursing or its equivalent.
- (b) A licensee who voluntarily withdraws from the program shall be considered terminated from the program.

[OAR Docket #10-585; filed 4-9-10]

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

[OAR Docket #10-444]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 2. Definitions [NEW]
590:10-2-1. General Definitions [NEW]
Subchapter 5. Contributions and Compensation
590:10-5-1. Maximum level [AMENDED]
Subchapter 7. Retirement Benefits
590:10-7-16. Rollovers [AMENDED]
590:10-7-19. Required minimum distributions [NEW]
590:10-7-20. Actuarial assumptions [NEW]
590:10-7-21. USERRA [NEW]
590:10-7-22. Qualified military service rights [NEW]
590:10-7-23. Compliance with Section 415 limitations on contributions and benefits [NEW]

AUTHORITY:

Oklahoma Public Employees Retirement System Board of Trustees; 74 O.S., §§ 902, 909.1, 915, 915.1, 915.2, 918.1

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SUPERSEDED EMERGENCY ACTION:

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Subchapter 2. Definitions [NEW]

590:10-2-1. General Definitions [NEW]

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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

The addition of 590:10-2-1 provides a definition of participating employer to clarify which employers can be participants in the System. This amendment was added as an emergency rule in 2009. The definition is necessary to ensure that the System complies with the Internal Revenue Code.

The amendment to 590:10-5-1 clarifies the maximum level of compensation for certain plan years used to calculate retirement benefits. The amendment also defines the term eligible member. The amendments are necessary in order to be in compliance with the Internal Revenue Code.

The amendment to 590:10-7-16 modifies the definition of eligible rollover distribution and other definitions related to rollovers. These modifications are necessary to update the rules relating to rollovers and be in compliance with the Internal Revenue Code.

The addition of 590:10-7-19 sets forth new provisions relating to required minimum distributions. The new rule provides for paying distributions to the member or beneficiaries of the member in accordance with the requirements of the Internal Revenue Code.

The addition of 590:10-7-20 sets forth a new provision relating to actuarial assumptions and is necessary to be in compliance with the Internal Revenue Code. This new rule sets forth existing policy that benefits are based on actuarial assumptions adopted by resolution of the Board of Trustees and that such resolution is part of the plan document.

The addition of 590:10-7-21 sets forth a new provision incorporating existing policy stating that qualified military service is governed by the Internal Revenue Code and the Uniformed Services Employment and Reemployment Rights Act of 1994.

590:10-7-22 is added to provide that members with qualified military service may be entitled to certain benefits the system may provide. The new rule also provides that differential wage payments shall be treated as earned compensation. This rule incorporates existing policy and is added to be in compliance with the Internal Revenue Code.

590:10-7-23 is added to be in compliance with the Internal Revenue Code Section 415 limitations on contributions and benefits. This new rule sets forth the specific limitations, adjustments, lump sum testing, COLAs, service purchases and repayment restrictions imposed by Section 415 of the Internal Revenue Code.

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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 MAY 13, 2010:

SUBCHAPTER 2. DEFINITIONS

590:10-2-1. General Definitions

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

"Participating employer" as defined in Section 902(25) of Title 74 of the Oklahoma Statutes means an eligible employer who has agreed to make contributions to the System on behalf of its employees provided such employer is the State, a political subdivision of the State, or an agency or instrumentality of the State. Participating employer shall not include any employer which is not permitted to participate in a qualified governmental pension plan as defined in Internal Revenue Code Section 414(d), 26 U.S.C. §414(d).

SUBCHAPTER 5. CONTRIBUTIONS AND COMPENSATION

590:10-5-1. Maximum level

(a) For service prior to July 1, 1994, members may elect to have a maximum compensation level for retirement purposes of up to ~~forty thousand dollars (\$40,000)~~ Forty Thousand Dollars (\$40,000.00) per annum. For service after July 1, 1994, contributions are required on all allowable compensation up to the maximum compensation level set by Statute.

(b) Effective with respect to plan years beginning on and after July 1, 1996, and before July 1, 2002, the annual compensation of a plan member which exceeds One Hundred Fifty Thousand Dollars (\$150,000.00) (as adjusted for cost-of-living increases under Section 401(a)(17)(B) of the Internal Revenue Code) shall be disregarded for purposes of computing employee and employer contributions to or benefits due from the retirement system. Effective only for the 1996 plan year, in determining the compensation of an employee eligible for consideration under this provision, the rules of Section 414(g)(6) of the Internal Revenue Code shall apply, except that in applying such rules, the term "family" shall include only the spouse of the member and any lineal descendants of the employee who have not attained age 19 before the close of the year.

(c) Effective ~~for~~ with respect to plan years beginning on and after ~~December 31, 2001~~ July 1, 2002, the ~~maximum annual compensation level for retirement purposes shall not exceed \$200,000.~~ of a plan member which exceeds Two Hundred Thousand Dollars (\$200,000.00). This limit shall be (as adjusted for cost-of-living increases in accordance with ~~section~~ Section 401(a)(17)(B) of the Internal Revenue Code) may not be taken into account in determining benefits or contributions due for any plan year. Annual compensation means

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compensation during the plan year or such other consecutive 12-month period over which compensation is otherwise determined under the plan (the determination period). The cost-of-living adjustment in effect for a calendar year applies to annual compensation for the determination period that begins with or within such calendar year. ~~The determination period is the plan year beginning July 1 through June 30. For retirement purposes in plan years beginning after December 31, 2001, the maximum compensation level for determination periods beginning before January 1, 2002, shall be \$200,000 provided all required contributions have been made on that salary. If the determination period consists of fewer than 12 months, the annual compensation limit is an amount equal to the otherwise applicable annual compensation limit multiplied by a fraction, the numerator of which is the number of months in the short determination period, and the denominator of which is 12. If the compensation for any prior determination period is taken into account in determining a plan member's contributions or benefits for the current plan year, the compensation for such prior determination period is subject to the applicable annual compensation limit in effect for that prior period.~~

(d) As used in this section, the term "eligible member" means a person who first became a member of the retirement system prior to the plan year beginning after December 31, 1995. Pursuant to Section 13212(d)(3)(A) of the Omnibus Budget Reconciliation Act of 1993, and the regulations issued under that section, eligible members are not subject to the limits of Section 401(a)(17) of the Internal Revenue Code, and the maximum compensation used in computing employee and employer contributions to or benefits due from the retirement system for eligible members shall be the maximum amount allowed by the retirement system to be so used on July 1, 1993. The limits referenced in subsections (b) and (c) above apply only to years beginning after December 31, 1995, and only to individuals who first become plan members in plan years beginning on and after July 1, 1996.

SUBCHAPTER 7. RETIREMENT BENEFITS

590:10-7-16. Rollovers

(a) This section applies to the Oklahoma Public Employees Retirement System and to the Uniform Retirement System for Justices and Judges.

(b) A distributee may elect to have eligible rollover distributions paid in a direct rollover to an eligible retirement plan the distributee specifies, pursuant to Section 401(a)(31) of the federal Internal Revenue Code.

(c) An eligible "Eligible rollover distribution" is means any distribution of all or any portion of the balance to the credit of the distributee, except that an eligible rollover distribution does not include: any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the distributee or the joint lives (or joint life expectancies) of the distributee and the distributee's designated beneficiary, or for a specified period of ten years or more; any distribution to the extent such distribution is required under ~~section~~ Section

401(a)(9) of the Internal Revenue Code; the portion of any ~~other distributions~~ distribution that is not includible in gross income, ~~except to the extent provided by paragraph (d) of this section; any distribution upon hardship of the employee; and any other distributions~~ distribution that is reasonably expected to total less than Two Hundred Dollars (\$200.00) during a the year. Effective January 1, 2002, the definition of eligible rollover distribution also includes a distribution to a surviving spouse, or to a spouse or former spouse who is an alternate payee under a qualified domestic relations order, as defined in Section 414(p) of the Internal Revenue Code.

(d) A ~~Effective January 1, 2002,~~ a portion of a distribution shall not fail to be an eligible rollover distribution merely because the portion consists of after-tax employee contributions ~~which that~~ are not includible in gross income. However, such portion may be transferred only:

(1) ~~to~~To an individual retirement account or an individual retirement annuity described in ~~section~~ Section 408(a) or (b) of the Internal Revenue Code or to a qualified defined contribution plan described in ~~section~~ Section 401(a) or 403(a) of the Internal Revenue Code;

(2) on or after January 1, 2007, to a qualified defined benefit plan described in Section 401(a) of the Internal Revenue Code or to an annuity contract described in Section 403(b) of the Internal Revenue Code that agrees to separately account for amounts so transferred (and earnings thereon), including separately accounting for the portion of ~~such the~~ distribution ~~which that~~ is includible in gross income and the portion of ~~such the~~ distribution ~~which that~~ is not so includible; or

(3) on or after January 1, 2008, to a Roth IRA described in Section 408A of the Internal Revenue Code.

(e) An eligible "Eligible retirement plan" is means any of the following that accepts the distributee's eligible rollover distribution:

(1) ~~an~~An individual retirement account described in ~~section~~ Section 408(a) of the Internal Revenue Code;

(2) an individual retirement annuity described in ~~section~~ Section 408(b) of the Internal Revenue Code;

(3) an annuity plan described in ~~section~~ Section 403(a) of the Internal Revenue Code;

(4) a qualified ~~plan~~ trust described in ~~section~~ Section 401(a) of the Internal Revenue Code;

(5) ~~effective January 1, 2002,~~ an annuity contract described in ~~section~~ Section 403(b) of the Internal Revenue Code; ~~or;~~

(6) ~~effective January 1, 2002,~~ an eligible deferred compensation a plan described in ~~section~~ eligible under Section 457(b) ~~which of~~ the Internal Revenue Code that is maintained by an eligible employer described in ~~section~~ 457(c)(1)(A) of the Code, that accepts the distributee's eligible rollover distribution. ~~a state, political subdivision of a state, or any agency or instrumentality of a state or a political subdivision of a state that agrees to separately account for amounts transferred into that plan from the retirement system; or~~

(7) ~~effective January 1, 2008,~~ a Roth IRA described in Section 408A of the Internal Revenue Code.

(f) ~~A distributee includes an employee, former employee, or for the limited purposes set forth in paragraph (h) of this section, a non-spouse beneficiary. — "Distributee" means an employee or former employee. In addition, It also includes the employee's or former employee's surviving spouse and the employee's or former employee's spouse or former spouse who is the alternate payee under a qualified domestic relations order, as defined in section—Section 414(p) of the Internal Revenue Code., are distributees with regard to the interest of the spouse or former spouse. Effective January 1, 2007, a distributee further includes a non-spouse beneficiary who is a designated beneficiary as defined by Section 401(a)(9)(E) of the Internal Revenue Code. However, a non-spouse beneficiary may rollover the distribution only to an individual retirement account or individual retirement annuity established for the purposes of receiving the distribution, and the account or annuity will be treated as an "inherited" individual retirement account or annuity.~~

(g) ~~A direct—"Direct rollover" is—means a payment by the plan to the eligible retirement plan specified by the distributee.~~

(h) ~~Effective January 1, 2007, a non-spouse beneficiary pursuant to section 402(e)(11) of the Code may elect to have any portion of an eligible rollover distribution paid directly to an individual retirement account described in section 408(a) of the Code, or an individual retirement annuity described in section 408(b) of the Code, established for the purpose of receiving the distribution. A rollover pursuant to this paragraph shall be treated as a rollover of an eligible rollover distribution only for purposes of section 402(c) of the Code.~~

590:10-7-19. Required minimum distributions

(a) The retirement system will pay all benefits in accordance with a good faith interpretation of the requirements of Section 401(a)(9) of the Internal Revenue Code and the regulations in effect under that section, as applicable to a governmental plan within the meaning of Section 414(d) of the Internal Revenue Code. The retirement system is subject to the following provisions:

(1) Distribution of a member's benefit must begin by the required beginning date, which is the later of the April 1 following the calendar year in which the member attains age 70 1/2 or April 1 of the year following the calendar year in which the member terminates. If a member fails to apply for retirement benefits by the later of either of those dates, the Board shall begin distribution of the monthly benefit as required by this rule in the form provided in 74 O.S. §901 et seq.

(2) The member's entire interest must be distributed over the member's life or the lives of the member and a designated beneficiary, or over a period not extending beyond the life expectancy of the member or of the member and a designated beneficiary.

(3) If a member dies after the required distribution of benefits has begun, the remaining portion of the member's interest must be distributed at least as rapidly as under the method of distribution before the member's death.

(4) If a member dies before required distribution of the member's benefits has begun, the member's entire interest must be either:

(A) Distributed (in accordance with federal regulations) over the life or life expectancy of the designated beneficiary, with the distributions beginning no later than December 31 of the calendar year following the calendar year of the member's death (or, if the designated beneficiary is the member's surviving spouse, beginning no later than the date on which the member would have attained age 70 1/2), or

(B) distributed within five (5) years of the member's death.

(5) The amount of an annuity paid to a member's beneficiary may not exceed the maximum determined under the incidental death benefit requirement of Section 401(a)(9)(G) of the Internal Revenue Code, and the minimum distribution incidental benefit rule under Treasury Regulation Section 1.401(a)(9)-6, Q&A-2.

(6) The death and disability benefits provided by the retirement system are limited by the incidental benefit rule set forth in Section 401(a)(9)(G) of the Internal Revenue Code and Treasury Regulation Section 1.401-1(b)(1)(i) or any successor regulation thereto. As a result, the total death or disability benefits payable may not exceed twenty-five percent (25%) of the cost for all of the members' benefits received from the retirement system.

(b) Notwithstanding the other provisions of this rule or the provisions of Treasury Regulations, benefit options may continue so long as the option satisfies Section 401(a)(9) of the Internal Revenue Code based on a reasonable and good faith interpretation of that section.

590:10-7-20. Actuarial assumptions

Effective as of July 1, 1989, the System will determine the amount of any benefit that is determined on the basis of actuarial assumptions using assumptions adopted by the Board of Trustees by resolution. Such benefits will not be subject to employer discretion. The resolutions adopted by the Board of Trustees for this purpose are incorporated as part of the plan document.

590:10-7-21. Reemployed veterans; compliance with Code Section 414(u)

Effective December 12, 1994, notwithstanding any other provision of the retirement system law, contributions, benefits and service credit with respect to qualified military service are governed by Section 414(u) of the Internal Revenue Code and the Uniformed Services Employment and Reemployment Rights Act of 1994.

590:10-7-22. Federal qualified military service rights

(a) Additional benefits if provided by Plan. Effective with respect to deaths occurring on or after January 1, 2007, while a member is performing qualified military service (as defined in Chapter 43 of Title 38, United States Code), to the extent required by Section 401(a)(37) of the Internal Revenue Code,

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survivors of a member in a State or local retirement or pension system, are entitled to any additional benefits that the system would otherwise provide if the member had resumed employment and then died, such as accelerated vesting or survivor benefits that are contingent on the member's death while employed.

(b) **Differential wage payments.** Beginning January 1, 2009, to the extent required by Sections 3401(h) and 414(u)(2) of the Internal Revenue Code, an individual receiving differential wage payments (while the individual is performing qualified military service as defined in Chapter 43 of Title 38, United States Code) from an employer shall be treated as employed by that employer and the differential wage payment shall be treated as earned compensation. This provision shall be applied to all similarly situated individuals in a reasonably equivalent manner.

590:10-7-23. Compliance with Section 415 limitations on contributions and benefits

(a) **General provisions.** Notwithstanding any other provisions of the retirement system to the contrary, the member contributions paid to and retirement benefits paid from the plan shall be limited to such extent as may be necessary to conform to the requirements of Section 415 of the Internal Revenue Code for a qualified pension plan.

(b) **Participation in other qualified plans: Aggregation of limits.**

(1) The 415(b) limit with respect to any member who at any time has been a member in any other defined benefit plan as defined in Section 414(j) of the Internal Revenue Code maintained by the member's employer in this plan shall apply as if the total benefits payable under all such defined benefit plans in which the member has been a member were payable from one (1) plan.

(2) The 415(c) limit with respect to any member who at any time has been a member in any other defined contribution plan as defined in Section 414(i) of the Internal Revenue Code maintained by the member's employer in this plan shall apply as if the total annual additions under all such defined contribution plans in which the member has been a member were payable from one (1) plan.

(c) **Basic 415(b) limitation.**

(1) Before January 1, 1995, a member may not receive an annual benefit that exceeds the limits specified in Section 415(b) of the Internal Revenue Code, subject to the applicable adjustments in that section. On and after January 1, 1995, a member may not receive an annual benefit that exceeds the dollar amount specified in Section 415(b)(1)(A) of the Internal Revenue Code, subject to the applicable adjustments in Section 415(b) of the Internal Revenue Code and subject to any additional limits that may be specified in the retirement system. In no event shall a member's benefit payable under the plan in any limitation year be greater than the limit applicable at the annuity starting date, as increased in subsequent years pursuant to Section 415(d) of the Internal Revenue Code and the regulations thereunder.

(2) For purposes of Section 415(b) of the Internal Revenue Code, the "annual benefit" means a benefit payable annually in the form of a straight life annuity (with no ancillary benefits) without regard to the benefit attributable to after-tax employee contributions (except pursuant to Section 415(n) of the Internal Revenue Code) and to rollover contributions (as defined in Section 415(b)(2)(A) of the Internal Revenue Code). The "benefit attributable" shall be determined in accordance with Treasury Regulations.

(d) **Adjustments to basic 415(b) limitation for form of benefit.** If the benefit under the plan is other than the form specified in subsection (c)(2), then the benefit shall be adjusted so that it is the equivalent of the annual benefit, using factors prescribed in Treasury Regulations.

(1) If the form of benefit without regard to the automatic benefit increase feature is not a straight life annuity or a qualified joint and survivor annuity, then the preceding sentence is applied by either reducing the Section 415(b) of the Internal Revenue Code limit applicable at the annuity starting date or adjusting the form of benefit to an actuarially equivalent amount (determined using the assumptions specified in Treasury Regulation Section 1.415(b)-1(c)(2)(ii)) that takes into account the additional benefits under the form of benefit as follows:

(2) For a benefit paid in a form to which Section 417(e)(3) of the Internal Revenue Code does not apply (that is, a monthly benefit), the actuarially equivalent straight life annuity benefit that is the greater of (or the reduced Limit applicable at the annuity starting date which is the "lesser of" when adjusted in accordance with the following assumptions):

(A) The annual amount of the straight life annuity (if any) payable to the member under the plan commencing at the same annuity starting date as the form of benefit to the member, or

(B) the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the form of benefit payable to the member, computed using a five percent (5%) interest assumption (or the applicable statutory interest assumption) and (i) for years prior to January 1, 2009, the applicable mortality tables described in Treasury Regulation Section 1.417(e)-1(d)(2) (Revenue Ruling 2001-62 or any subsequent Revenue Ruling modifying the applicable provisions of Revenue Rulings 2001-62), and (ii) for years after December 31, 2008, the applicable mortality tables described in Section 417(e)(3)(B) of the Internal Revenue Code (Notice 2008-85 or any subsequent Internal Revenue Service guidance implementing Section 417(e)(3)(B) of the Internal Revenue Code); or

(3) For a benefit paid in a form to which Section 417(e)(3) of the Internal Revenue Code applies (that is, a lump sum benefit), the actuarially equivalent straight life annuity benefit that is the greatest of (or the reduced Section 415(b) of the Internal Revenue Code limit applicable

at the annuity starting date which is the "least of" when adjusted in accordance with the following assumptions):

(A) The annual amount of the straight life annuity commencing at the annuity starting date that has the same actuarial present value as the particular form of benefit payable, computed using the interest rate and mortality table, or tabular factor, specified in the plan for actuarial experience;

(B) the annual amount of the straight life annuity commencing at the annuity starting date that has the same actuarial present value as the particular form of benefit payable, computed using a 5.5 percent interest assumption (or the applicable statutory interest assumption) and (i) for years prior to January 1, 2009, the applicable mortality tables described in Treasury Regulation Section 1.417(e)-1(d)(2) (Revenue Ruling 2001-62 or any subsequent Revenue Ruling modifying the applicable provisions of Revenue Rulings 2001-62), and (ii) for years after December 31, 2008, the applicable mortality tables described in Section 417(e)(3)(B) of the Internal Revenue Code (Notice 2008-85 or any subsequent Internal Revenue Service guidance implementing Section 417(e)(3)(B) of the Internal Revenue Code); or

(C) the annual amount of the straight life annuity commencing at the annuity starting date that has the same actuarial present value as the particular form of benefit payable (computed using the applicable interest rate for the distribution under Treasury Regulation Section 1.417(e)-1(d)(3) (the 30-year Treasury rate (prior to January 1 2007, using the rate in effect for the month prior to retirement, and on and after January 1, 2007, using the rate in effect for the first day of the plan year with a one-year stabilization period))) and (i) for years prior to January 1, 2009, the applicable mortality tables described in Treasury Regulation Section 1.417(e)-1(d)(2) (Revenue Ruling 2001-62 or any subsequent Revenue Ruling modifying the applicable provisions of Revenue Rulings 2001-62), and (ii) for years after December 31, 2008, the applicable mortality tables described in Section 417(e)(3)(B) of the Internal Revenue Code (Notice 2008-85 or any subsequent Internal Revenue Service guidance implementing Section 417(e)(3)(B) of the Internal Revenue Code), divided by 1.05.

(e) **Benefits not taken into account for 415(b) limitation.** For purposes of this section, the following benefits shall not be taken into account in applying these limits:

- (1) Any ancillary benefit which is not directly related to retirement income benefits;
- (2) that portion of any joint and survivor annuity that constitutes a qualified joint and survivor annuity;
- (3) any other benefit not required under Section 415(b)(2) of the Internal Revenue Code and Treasury Regulations thereunder to be taken into account for purposes of the limitation of Section 415(b)(1) of the Internal Revenue Code.

(f) **Other adjustments in 415(b) limitation.**

(1) In the event the member's retirement benefits become payable before age sixty-two (62), the limit prescribed by this section shall be reduced in accordance with Treasury Regulations pursuant to the provisions of Section 415(b) of the Internal Revenue Code, so that such limit (as so reduced) equals an annual straight life benefit (when such retirement income benefit begins) which is equivalent to a One Hundred Sixty Thousand Dollar (\$160,000.00) (as adjusted) annual benefit beginning at age sixty-two (62).

(2) In the event the member's benefit is based on at least fifteen (15) years of service as a full-time employee of any police or fire department or on fifteen (15) years of military service, the adjustments provided for in paragraph (1) of this subsection shall not apply.

(3) The reductions provided for in paragraph (1) of this subsection shall not be applicable to pre-retirement disability benefits or pre-retirement death benefits.

(g) **Less than ten (10) years of service adjustment for 415(b) limitations.** The maximum retirement benefits payable to any member who has completed less than ten (10) years of service shall be the amount determined under subsection (c) of this section multiplied by a fraction, the numerator of which is the number of the member's years of service and the denominator of which is ten (10). The reduction provided by this subsection cannot reduce the maximum benefit below ten percent (10%). The reduction provided for in this subsection shall not be applicable to pre-retirement disability benefits or pre-retirement death benefits.

(h) **Ten Thousand Dollar (\$10,000.00) limit.** Notwithstanding the foregoing, the retirement benefit payable with respect to a member shall be deemed not to exceed the 415 limit if the benefits payable, with respect to such member under this plan and under all other qualified defined benefit pension plans to which the member's employer contributes, do not exceed Ten Thousand Dollars (\$10,000.00) for the applicable limitation year and for any prior limitation year and the employer has not at any time maintained a qualified defined contribution plan in which the member participated.

(i) **Effect of COLA without a lump sum component on 415(b) testing.** Effective on and after January 1, 2009, for purposes of applying the limits under Section 415(b) of the Internal Revenue Code (the "Limit") to a member with no lump sum benefit, the following will apply:

(1) A member's applicable Limit will be applied to the member's annual benefit in the member's first limitation year without regard to any cost-of-living adjustments under Title 74 O.S. §901 et seq;

(2) to the extent that the member's annual benefit equals or exceeds the Limit, the member will no longer be eligible for cost-of-living increases until such time as the benefit plus the accumulated increases are less than the Limit; and

(3) thereafter, in any subsequent limitation year, a member's annual benefit, including any cost-of-living increases under Title 74 O.S. §901 et seq, shall be tested under the then applicable benefit Limit including any adjustment to the Section 415(b)(1)(A) of the Internal

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Revenue Code dollar limit under Section 415(d) of the Internal Revenue Code, and the regulations thereunder.

(j) **Effect of COLA with a lump sum component on 415(b) testing.** On and after January 1, 2009, with respect to a member who receives a portion of the member's annual benefit in a lump sum, a member's applicable Limit will be applied taking into consideration cost-of-living increases as required by Section 415(b) of the Internal Revenue Code and applicable Treasury Regulations.

(k) **Section 415(c) limitations on contributions and other additions.** After-tax member contributions or other annual additions with respect to a member may not exceed the lesser of Forty Thousand Dollars (\$40,000.00) (as adjusted pursuant to Section 415(d) of the Internal Revenue Code) or one hundred percent (100%) of the member's compensation.

(1) Annual additions are defined to mean the sum (for any year) of employer contributions to a defined contribution plan, member contributions, and forfeitures credited to a member's individual account. Member contributions are determined without regard to rollover contributions and to picked-up employee contributions that are paid to a defined benefit plan.

(2) For purposes of applying Section 415(c) of the Internal Revenue Code and for no other purpose, the definition of compensation where applicable will be compensation actually paid or made available during a limitation year, except as noted below and as permitted by Treasury Regulation Section 1.415(c)-2, or successor regulation; provided, however, that member contributions picked up under Section 414(h) of the Internal Revenue Code shall not be treated as compensation.

(3) Compensation will be defined as wages within the meaning of Section 3401(a) of the Internal Revenue Code and all other payments of compensation to an employee by an employer for which the employer is required to furnish the employee a written statement under Sections 6041(d), 6051(a)(3) and 6052 of the Internal Revenue Code and will be determined without regard to any rules under Section 3401(a) of the Internal Revenue Code that limit the remuneration included in wages based on the nature or location of the employment or the services performed (such as the exception for agricultural labor in Section 3401(a)(2) of the Internal Revenue Code).

(A) However, for limitation years beginning after December 31, 1997, compensation will also include amounts that would otherwise be included in compensation but for an election under Section 125(a), 402(e)(3), 402(h)(1)(B), 402(k), or 457(b) of the Internal Revenue Code. For limitation years beginning after December 31, 2000, compensation shall also include any elective amounts that are not includible in the gross income of the member by reason of Section 132(f)(4) of the Internal Revenue Code.

(B) For limitation years beginning on and after January 1, 2009, compensation for the limitation year shall also include compensation paid by the later of 2

1/2 months after a member's severance from employment or the end of the limitation year that includes the date of the member's severance from employment if:

(i) The payment is regular compensation for services during the member's regular working hours, or compensation for services outside the member's regular working hours (such as overtime or shift differential), commissions, bonuses or other similar payments, and, absent a severance from employment, the payments would have been paid to the member while the member continued in employment with the employer; or

(ii) the payment is for unused accrued bona fide sick, vacation or other leave that the member would have been able to use if employment had continued.

(C) Any payments not described in subparagraph (B) of this paragraph are not considered compensation if paid after severance from employment, even if they are paid within 2 1/2 months following severance from employment, except for payments to the individual who does not currently perform services for the employer by reason of qualified military service (within the meaning of Section 414(u)(1) of the Internal Revenue Code) to the extent these payments do not exceed the amounts the individual would have received if the individual had continued to perform services for the employer rather than entering qualified military service.

(D) An employee who is in qualified military service (within the meaning of Section 414(u)(1) of the Internal Revenue Code) shall be treated as receiving compensation from the employer during such period of qualified military service equal to (i) the compensation the employee would have received during such period if the employee were not in qualified military service, determined based on the rate of pay the employee would have received from the employer but for the absence during the period of qualified military service, or (ii) if the compensation the employee would have received during such period was not reasonably certain, the employee's average compensation from the employer during the twelve (12) month period immediately preceding the qualified military service (or, if shorter, the period of employment immediately preceding the qualified military service).

(E) Back pay, within the meaning of Treasury Regulation Section 1.415(c)-2(g)(8), shall be treated as compensation for the limitation year to which the back pay relates to the extent the back pay represents wages and compensation that would otherwise be included under this definition.

(4) For limitation years beginning on or after January 1, 2009, a member's compensation for purposes of subsection (k) shall not exceed the annual limit under Section 401(a)(17) of the Internal Revenue Code.

(l) **Service purchases under Section 415(n).**

(1) Effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, if a member makes one or more contributions to purchase permissive service credit under the plan, then the requirements of Section 415(n) of the Internal Revenue Code will be treated as met only if:

(A) The requirements of Section 415(b) of the Internal Revenue Code are met, determined by treating the accrued benefit derived from all such contributions as an annual benefit for purposes of Section 415(b) of the Internal Revenue Code, or

(B) the requirements of Section 415(c) of the Internal Revenue Code are met, determined by treating all such contributions as annual additions for purposes of Section 415(c) of the Internal Revenue Code.

(2) For purposes of applying this section, the system will not fail to meet the reduced limit under Section 415(b)(2)(C) of the Internal Revenue Code solely by reason of this paragraph and will not fail to meet the percentage limitation under Section 415(c)(1)(B) of the Internal Revenue Code solely by reason of this section.

(3) For purposes of this section the term "permissive service credit" means service credit:

(A) Recognized by the system for purposes of calculating a member's benefit under the system,

(B) which such member has not received under the system, and

(C) which such member may receive only by making a voluntary additional contribution, in an amount determined under the system, which does not exceed the amount necessary to fund the benefit attributable to such service credit. Effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, such term may include service credit for periods for which there is no performance of service, and, notwithstanding subparagraph (B) of this paragraph, may include service credited in order to provide an increased benefit for service credit which a member is receiving under the system.

(4) The system will fail to meet the requirements of this section if:

(A) More than five (5) years of nonqualified service credit are taken into account for purposes of this paragraph, or

(B) any nonqualified service credit is taken into account under this paragraph before the member has at least five (5) years of participation under the system.

(5) For purposes of paragraph (4) of this subsection, effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, the term "nonqualified service credit" means permissive service credit other than that allowed with respect to:

(A) Service (including parental, medical, sabbatical, and similar leave) as an employee of the Government of the United States, any State or political subdivision thereof, or any agency or instrumentality of any of the foregoing (other than military service or

service for credit which was obtained as a result of a repayment described in Section 415(k)(3) of the Internal Revenue Code),

(B) service (including parental, medical, sabbatical, and similar leave) as an employee (other than as an employee described in subparagraph (A) of this paragraph) of an education organization described in Section 170(b)(1)(A)(ii) of the Internal Revenue Code which is a public, private, or sectarian school which provides elementary or secondary education (through grade 12), or a comparable level of education, as determined under the applicable law of the jurisdiction in which the service was performed,

(C) service as an employee of an association of employees who are described in subparagraph (A) of this paragraph, or

(D) military service (other than qualified military service under Section 414(u) of the Internal Revenue Code) recognized by the system.

(6) In the case of service described in subparagraphs (A), (B), or (C) of this paragraph, such service will be nonqualified service if recognition of such service would cause a member to receive a retirement benefit for the same service under more than one plan.

(7) In the case of a trustee-to-trustee transfer after December 31, 2001, to which Section 403(b)(13)(A) of the Internal Revenue Code or Section 457(e)(17)(A) of the Internal Revenue Code applies (without regard to whether the transfer is made between plans maintained by the same employer):

(A) The limitations of paragraph (4) of this subsection will not apply in determining whether the transfer is for the purchase of permissive service credit, and

(B) the distribution rules applicable under federal law to the system will apply to such amounts and any benefits attributable to such amounts.

(8) For an eligible member, the limitation of Section 415(c)(1) of the Internal Revenue Code shall not be applied to reduce the amount of permissive service credit which may be purchased to an amount less than the amount which was allowed to be purchased under the terms of a Plan as in effect on August 5, 1997. For purposes of this paragraph an eligible member is an individual who first became a member in the system before January 1, 1998.

(m) **Modification of contributions for 415(c) and 415(n) purposes.** Notwithstanding any other provision of law to the contrary, the system may modify a request by a member to make a contribution to the system if the amount of the contribution would exceed the limits provided in Section 415 of the Internal Revenue Code by using the following methods:

(1) If the law requires a lump sum payment for the purchase of service credit, the system may establish a periodic payment plan for the member to avoid a contribution in excess of the limits under Section 415(c) or 415(n) of the Internal Revenue Code.

(2) If payment pursuant to paragraph (1) of this subsection will not avoid a contribution in excess of the limits

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imposed by Section 415(c) or 415(n) of the Internal Revenue Code, the system may either reduce the member's contribution to an amount within the limits of those sections or refuse the member's contribution.

(n) **Repayments of cashouts.** Any repayment of contributions (including interest thereon) to the plan with respect to an amount previously refunded upon a forfeiture of service credit under the plan or another governmental plan maintained by the retirement system shall not be taken into account for purposes of Section 415 of the Internal Revenue Code, in accordance with applicable Treasury Regulations.

(o) **Reduction of benefits priority.** Reduction of benefits and/or contributions to all plans, where required, shall be accomplished by first reducing the member's benefit under any defined benefit plans in which the member participated, such reduction to be made first with respect to the plan in which the member most recently accrued benefits and thereafter in such priority as shall be determined by the plan and the plan administrator of such other plans, and next, by reducing or allocating excess forfeitures for defined contribution plans in which the member participated, such reduction to be made first with respect to the plan in which the member most recently accrued benefits and thereafter in such priority as shall be established by the plan and the plan administrator for such other plans provided, however, that necessary reductions may be made in a different manner and priority pursuant to the agreement of the plan and the plan administrator of all other plans covering such member.

[OAR Docket #10-444; filed 3-29-10]

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

[OAR Docket #10-445]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions

590:15-1-1. Purpose; defined benefit plan [AMENDED]

590:15-1-4. Average monthly salary and maximum compensation [AMENDED]

590:15-1-11. Maximum benefits [AMENDED]

590:15-1-12. Rollovers [AMENDED]

590:15-1-18. Qualified military service rights [NEW]

590:15-1-19. Actuarial assumptions [NEW]

590:15-1-20. Employee contributions vested; forfeiture [NEW]

590:15-1-21. Required minimum distributions [NEW]

AUTHORITY:

Oklahoma Public Employees Retirement System Board of Trustees; 20 O.S., §§ 1101.1, 1103, 1103.2, 1103.3, 1104.1, 1104.2, 1108

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May 13, 2010

ANALYSIS:

The amendment to 590:15-1-1 clarifies that the plan is a qualified defined benefit plan in accordance with the Internal Revenue Code.

The amendment to 590:15-1-4 clarifies the maximum level of compensation for certain plan years used to calculate retirement benefits. The amendment also defines the term eligible member. The amendments are necessary in order to be in compliance with the Internal Revenue Code.

The amendment to 590:15-1-11 is needed to be in compliance with the Internal Revenue Code Section 415 limits on contributions and benefits. The amendment sets forth the specific limitations, adjustments, lump sum testing, COLAs, service purchases and repayment restrictions imposed by Section 415 of the Internal Revenue Code.

The amendment to 590:15-1-12 modifies the definition of eligible rollover distribution and other definitions related to rollovers. These modifications are necessary to update the rules relating to rollover distributions and be in compliance with the Internal Revenue Code.

The addition of 590:15-1-18 sets forth new provisions providing that members with qualified military service may be entitled to certain benefits if the system otherwise provides such benefits. The new rule also provides that differential wage payments shall be treated as earned compensation. This rule incorporates existing policy and is added to be in compliance with the Internal Revenue Code.

The addition of 590:15-1-19 adds a provision relating to actuarial assumptions and is necessary to be in compliance with the Internal Revenue Code. This rule sets forth existing policy that benefits are based on actuarial assumptions adopted by resolution of the Board of Trustees and that such resolution is part of the plan document.

The addition of 590:15-1-20 clarifies that a member is 100% vested in his or her employee contributions to the plan. It also provides that any forfeitures of benefits are not used to pay benefit increases, but used reduce employer contributions. This rule is necessary to be in compliance with the Internal Revenue Code.

The addition of 590:15-1-21 sets forth new provisions relating to required minimum distributions. The new rule provides for paying distributions to members or beneficiaries of the member in accordance with the requirements of the Internal Revenue Code.

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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 MAY 13, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

590:15-1-1. Purpose; defined benefit plan

(a) The rules of this Chapter have been adopted to establish policies and procedures for implementing and administering the Uniform Retirement System for Justices and Judges. The Board of Trustees of the Oklahoma Public Employees Retirement System shall be responsible for the general oversight

of the Judicial System and shall generally manage the two Systems in the same manner, except where the statutes or rules specifically provide otherwise.

(b) The Judicial System is established as a qualified defined benefit plan pursuant to Sections 401(a) and 414(d) of the Internal Revenue Code or such other provision of the Internal Revenue Code as applicable and applicable Treasury regulations and other guidance.

590:15-1-4. Average monthly salary and maximum compensation

(a) **Retiring prior to June 30, 2004.** For any Justice or Judge retiring prior to June 30, 2004, average monthly salary shall be computed averaging the last thirty-six (36) consecutive months of salary received as an active ~~Judge or Justice.~~ Justice or Judge. Partial months will be included in the average.

(b) **Retiring after June 30, 2004.** For any Justice or Judge retiring after June 30, 2004, average monthly salary shall be calculated as follows:

(1) The highest thirty-six (36) months of salary, excluding longevity payments, received as a Justice or Judge will be determined and totaled;

(2) If applicable, the three (3) highest annual longevity payments upon which retirement contributions have been paid will be added to the sum of the highest thirty-six (36) months of salary. If a Justice or Judge is scheduled to receive a prorated longevity payment at or near the effective date of retirement, the prorated longevity payment will be used only in the amount actually paid for which contributions are withheld and if it is one of the three (3) highest longevity payments;

(3) Average monthly salary will be determined by adding the total of the highest thirty-six (36) months of salary to the highest three (3) longevity payments if applicable, and dividing by thirty-six (36). This calculation is illustrated by the following formula: Total of Thirty-six Months of Highest Salaries + Three Highest Longevity Payments ÷ 36 = Average Monthly Salary;

(c) **Multiplier; benefit limit.** The monthly benefit amount shall be determined by multiplying four percent (4%) of the average monthly salary by the total number of years of credited service, provided the monthly benefit may not exceed one hundred percent (100%) of the average monthly salary calculated in subsection (b) of this rule.

(d) **Prior reported compensation.** Except for errors in contribution or service, any amounts of compensation reported to the System as salary prior to June 30, 2004, and for which retirement contributions were paid may be used in the calculations provided in this rule.

(e) **Limits from July 1, 1996 to June 30, 2002.** Effective with respect to plan years beginning on and after July 1, 1996, and before July 1, 2002, the annual compensation of a plan member which exceeds One Hundred Fifty Thousand Dollars (\$150,000.00) (as adjusted for cost-of-living increases under Section 401(a)(17)(B) of the Internal Revenue Code) shall be disregarded for purposes of computing employee and employer contributions to or benefits due from the retirement system.

Effective only for the 1996 plan year, in determining the compensation of an employee eligible for consideration under this provision, the rules of Section 414(g)(6) of the Internal Revenue Code shall apply, except that in applying such rules, the term "family" shall include only the spouse of the member and any lineal descendants of the employee who have not attained age 19 before the close of the year.

(ef) **Limits from July 1, 2002.** Effective for with respect to plan years beginning on or after December 31, 2001, July 1, 2002, the maximum annual compensation level for retirement purposes shall not exceed \$200,000. of a plan member which exceeds Two Hundred Thousand Dollars (\$200,000.00) This limit shall be (as adjusted for cost-of-living increases in accordance with section Section 401(a)(17)(B) of the Internal Revenue Code) may not be taken into account in determining benefits or contributions due for any plan year. "Annual compensation" means compensation during the plan year or such other consecutive 12-month period over which compensation is otherwise determined under the plan (the determination period). The cost-of-living adjustment in effect for a calendar year applies to annual compensation for the determination period that begins with or within such calendar year.—The determination period is the plan year beginning July 1 through June 30. For retirement purposes in plan years beginning after December 31, 2001, the maximum compensation level for determination periods beginning before January 1, 2002, shall be \$200,000 provided all required contributions have been made on that salary. If the determination period consists of fewer than 12 months, the annual compensation limit is an amount equal to the otherwise applicable annual compensation limit multiplied by a fraction, the numerator of which is the number of months in the short determination period, and the denominator of which is 12. If the compensation for any prior determination period is taken into account in determining a plan member's contributions or benefits for the current plan year, the compensation for such prior determination period is subject to the applicable annual compensation limit in effect for that prior period.

(g) **Definitions.** As used in this section, the term "eligible member" means a person who first became a member of the retirement system prior to the plan year beginning after December 31, 1995. Pursuant to Section 13212(d)(3)(A) of Omnibus Budget Reconciliation Act of 1993, and the regulations issued under that section, eligible members are not subject to the limits of Section 401(a)(17) of the Internal Revenue Code, and the maximum compensation used in computing employee and employer contributions to or benefits due from the retirement system for eligible members shall be the maximum amount allowed by the retirement system to be so used on July 1, 1993. The limits referenced in subsections (e) and (f) above apply only to years beginning after December 31, 1995, and only to individuals who first become plan members in plan years beginning on and after July 1, 1996.

590:15-1-11. Maximum benefits

~~Benefits payable from the System may not exceed the maximum benefits specified by Section 415(b) of the federal Internal Revenue Code. In Order to meet the requirements of~~

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Section 415(b)(2)(E)(v) of the federal Internal Revenue Code, the System shall use the applicable mortality table specified in Rev. Rul. 95-6, 1995-1 C.B. 80.

(a) **General provisions.** Notwithstanding any other provisions of the System to the contrary, the member contributions paid to and retirement benefits paid from the Plan shall be limited to such extent as may be necessary to conform to the requirements of Section 415(b) of the Internal Revenue Code for a qualified pension plan.

(b) **Participation in other qualified plans: Aggregation of limits.**

(1) The 415(b) limit with respect to any member who at any time has been a member in any other defined benefit plan as defined in Section 414(j) of the Internal Revenue Code maintained by the member's employer in this plan shall apply as if the total benefits payable under all such defined benefit plans in which the member has been a member were payable from one (1) plan.

(2) The 415(c) limit with respect to any member who at any time has been a member in any other defined contribution plan as defined in Section 414(i) of the Internal Revenue Code maintained by the member's employer in this plan shall apply as if the total annual additions under all such defined contribution plans in which the member has been a member were payable from one (1) plan.

(c) **Basic 415(b) limitation.**

(1) Before January 1, 1995, a member may not receive an annual benefit that exceeds the limits specified in Section 415(b) of the Internal Revenue Code, subject to the applicable adjustments in that section. On and after January 1, 1995, a member may not receive an annual benefit that exceeds the dollar amount specified in Section 415(b)(1)(A) of the Internal Revenue Code, subject to the applicable adjustments in Section 415(b) of the Internal Revenue Code and subject to any additional limits that may be specified in the retirement system. In no event shall a member's benefit payable under the plan in any limitation year be greater than the limit applicable at the annuity starting date, as increased in subsequent years pursuant to Section 415(d) of the Internal Revenue Code and the regulations thereunder.

(2) For purposes of Section 415(b) of the Internal Revenue Code, the "annual benefit" means a benefit payable annually in the form of a straight life annuity (with no ancillary benefits) without regard to the benefit attributable to after-tax employee contributions (except pursuant to Section 415(n) of the Internal Revenue Code) and to rollover contributions (as defined in Section 415(b)(2)(A) of the Internal Revenue Code). The "benefit attributable" shall be determined in accordance with Treasury Regulations.

(d) **Adjustments to basic 415(b) limitation for form of benefit.** If the benefit under the plan is other than the form specified in subsection (c)(2), then the benefit shall be adjusted so that it is the equivalent of the annual benefit, using factors prescribed in Treasury Regulations.

(1) If the form of benefit without regard to the automatic benefit increase feature is not a straight life annuity or a qualified joint and survivor annuity, then the preceding sentence is applied by either reducing the Section 415(b) of the Internal Revenue Code limit applicable at the annuity starting date or adjusting the form of benefit to an actuarially equivalent amount (determined using the assumptions specified in Treasury Regulation Section 1.415(b)-1(c)(2)(ii) that takes into account the additional benefits under the form of benefit as follows:

(2) For a benefit paid in a form to which Section 417(e)(3) of the Internal Revenue Code does not apply (that is, a monthly benefit), the actuarially equivalent straight life annuity benefit that is the greater of (or the reduced Limit applicable at the annuity starting date which is the "lesser of" when adjusted in accordance with the following assumptions):

(A) The annual amount of the straight life annuity (if any) payable to the member under the plan commencing at the same annuity starting date as the form of benefit to the member, or

(B) The annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the form of benefit payable to the member, computed using a five percent (5%) interest assumption (or the applicable statutory interest assumption) and (i) for years prior to January 1, 2009, the applicable mortality rate for the distribution under Treasury Regulation Section 1.417(e)-1(d)(2) (the mortality table specified in Revenue Ruling 2001-62 or any subsequent Revenue Ruling modifying the applicable provisions of Revenue Ruling 2001-62), and (ii) for years after December 31, 2008, the applicable mortality tables described in Section 417(e)(3)(B) of the Internal Revenue Code (Notice 2008-85 or any subsequent Internal Revenue Service guidance implementing Section 417(e)(3)(B) of the Internal Revenue Code); or

(3) For a benefit paid in a form to which Section 417(e)(3) of the Internal Revenue Code applies (that is, a lump sum benefit), the actuarially equivalent straight life annuity benefit that is the greatest of (or the reduced Section 415(b) of the Internal Revenue Code limit applicable at the annuity starting date which is the "least of" when adjusted in accordance with the following assumptions):

(A) The annual amount of the straight life annuity commencing at the annuity starting date that has the same actuarial present value as the particular form of benefit payable, computed using the interest rate and mortality table, or tabular factor, specified in the plan for actuarial experience;

(B) the annual amount of the straight life annuity commencing at the annuity starting date that has the same actuarial present value as the particular form of benefit payable, computed using a 5.5 percent interest assumption (or the applicable statutory interest assumption) and (i) for years prior to January 1, 2009,

the applicable mortality rate for the distribution under Treasury Regulation Section 1.417(e)-1(d)(2) (the mortality table specified in Revenue Ruling 2001-62 or any subsequent Revenue Ruling modifying the applicable provisions of Revenue Ruling 2001-62), and (ii) for years after December 31, 2008, the applicable mortality tables described in Section 417(e)(3)(B) of the Internal Revenue Code (Notice 2008-85 or any subsequent Internal Revenue Service guidance implementing Section 417(e)(3)(B) of the Internal Revenue Code); or

(C) the annual amount of the straight life annuity commencing at the annuity starting date that has the same actuarial present value as the particular form of benefit payable (computed using the applicable interest rate for the distribution under Treasury Regulation Section 1.417(e)-1(d)(3) (the 30-year Treasury rate (prior to January 1 2007, using the rate in effect for the month prior to retirement, and on and after January 1, 2007, using the rate in effect for the first day of the plan year with a one-year stabilization period))) and (i) for years prior to January 1, 2009, the applicable mortality rate for the distribution under Treasury Regulation Section 1.417(e)-1(d)(2) (the mortality table specified in Revenue Ruling 2001-62 or any subsequent Revenue Ruling modifying the applicable provisions of Revenue Ruling 2001-62), and (ii) for years after December 31, 2008, the applicable mortality tables described in Section 417(e)(3)(B) of the Internal Revenue Code (Notice 2008-85 or any subsequent Internal Revenue Service guidance implementing Section 417(e)(3)(B) of the Internal Revenue Code), divided by 1.05.

(e) Benefits not taken into account for 415(b) limitation.

For purposes of this section, the following benefits shall not be taken into account in applying these limits:

- (1) Any ancillary benefit which is not directly related to retirement income benefits;
- (2) that portion of any joint and survivor annuity that constitutes a qualified joint and survivor annuity;
- (3) any other benefit not required under Section 415(b)(2) of the Internal Revenue Code and Treasury Regulations thereunder to be taken into account for purposes of the limitation of Section 415(b)(1) of the Internal Revenue Code.

(f) Other adjustments in 415(b) limitation.

- (1) In the event the member's retirement benefits become payable before age sixty-two (62), the limit prescribed by this section shall be reduced in accordance with Treasury Regulations pursuant to the provisions of Section 415(b) of the Internal Revenue Code, so that such limit (as so reduced) equals an annual straight life benefit (when such retirement income benefit begins) which is equivalent to a One Hundred Sixty Thousand Dollar (\$160,000.00) (as adjusted) annual benefit beginning at age sixty-two (62).
- (2) In the event the member's benefit is based on at least fifteen (15) years of service as a full-time employee of

any police or fire department or on fifteen (15) years of military service, the adjustments provided for in paragraph (1) of this subsection shall not apply.

(3) The reductions provided for in paragraph (1) of this subsection shall not be applicable to pre-retirement disability benefits or pre-retirement death benefits.

(g) Less than ten (10) years of service adjustment for 415(b) limitations. The maximum retirement benefits payable to any member who has completed less than ten (10) years of service shall be the amount determined under subsection (c) of this section multiplied by a fraction, the numerator of which is the number of the member's years of service and the denominator of which is ten (10). The reduction provided by this subsection cannot reduce the maximum benefit below ten percent (10%). The reduction provided for in this subsection shall not be applicable to pre-retirement disability benefits or pre-retirement death benefits.

(h) Ten Thousand Dollar (\$10,000.00) limit. Notwithstanding the foregoing, the retirement benefit payable with respect to a member shall be deemed not to exceed the 415 limit if the benefits payable, with respect to such member under this plan and under all other qualified defined benefit pension plans to which the member's employer contributes, do not exceed Ten Thousand Dollars (\$10,000.00) for the applicable limitation year and for any prior limitation year and the employer has not any time maintained a qualified defined contribution plan in which the member participated.

(i) Effect of COLA without a lump sum component on 415(b) testing. Effective on and after January 1, 2009, for purposes of applying the limits under Section 415(b) of the Internal Revenue Code (the "Limit") to a member with no lump sum benefit, the following will apply:

- (1) A member's applicable Limit will be applied to the member's annual benefit in the member's first limitation year without regard to any cost-of-living adjustments;
- (2) to the extent that the member's annual benefit equals or exceeds the Limit, the member will no longer be eligible for cost-of-living increases until such time as the benefit plus the accumulated increases are less than the Limit; and
- (3) thereafter, in any subsequent limitation year, a member's annual benefit, including any cost-of-living increases, shall be tested under the then applicable benefit Limit including any adjustment to the Section 415(b)(1)(A) of the Internal Revenue Code dollar limit under Section 415(d) of the Internal Revenue Code, and the regulations thereunder.

(j) Effect of COLA with a lump sum component on 415(b) testing. On and after January 1, 2009, with respect to a member who receives a portion of the member's annual benefit in a lump sum, a member's applicable Limit will be applied taking into consideration cost-of-living increases as required by Section 415(b) of the Internal Revenue Code and applicable Treasury Regulations.

(k) Section 415(c) limitations on contributions and other additions. After-tax member contributions or other annual additions with respect to a member may not exceed the lesser of Forty Thousand Dollars (\$40,000.00) (as adjusted pursuant to

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Section 415(d) of the Internal Revenue Code) or one hundred percent (100%) of the member's compensation.

(1) Annual additions are defined to mean the sum (for any year) of employer contributions to a defined contribution plan, member contributions, and forfeitures credited to a member's individual account. Member contributions are determined without regard to rollover contributions and to picked-up employee contributions that are paid to a defined benefit plan.

(2) For purposes of applying Section 415(c) of the Internal Revenue Code and for no other purpose, the definition of compensation where applicable will be compensation actually paid or made available during a limitation year, except as noted below and as permitted by Treasury Regulation Section 1.415(c)-2, or successor regulation; provided, however, that member contributions picked up under Section 414(h) of the Internal Revenue Code shall not be treated as compensation.

(3) Compensation will be defined as wages within the meaning of Section 3401(a) of the Internal Revenue Code and all other payments of compensation to an employee by an employer for which the employer is required to furnish the employee a written statement under Sections 6041(d), 6051(a)(3) and 6052 of the Internal Revenue Code and will be determined without regard to any rules under Section 3401(a) of the Internal Revenue Code that limit the remuneration included in wages based on the nature or location of the employment or the services performed (such as the exception for agricultural labor in Section 3401(a)(2) of the Internal Revenue Code).

(A) However, for limitation years beginning after December 31, 1997, compensation will also include amounts that would otherwise be included in compensation but for an election under Section 125(a), 402(e)(3), 402(h)(1)(B), 402(k), or 457(b) of the Internal Revenue Code. For limitation years beginning after December 31, 2000, compensation shall also include any elective amounts that are not includible in the gross income of the member by reason of Section 132(f)(4) of the Internal Revenue Code.

(B) For limitation years beginning on and after January 1, 2009, compensation for the limitation year shall also include compensation paid by the later of 2 1/2 months after a member's severance from employment or the end of the limitation year that includes the date of the member's severance from employment if:

(i) The payment is regular compensation for services during the member's regular working hours, or compensation for services outside the member's regular working hours (such as overtime or shift differential), commissions, bonuses or other similar payments, and, absent a severance from employment, the payments would have been paid to the member while the member continued in employment with the employer; or

(ii) the payment is for unused accrued bona fide sick, vacation or other leave that the member

would have been able to use if employment had continued.

(C) Any payments not described in subparagraph (B) of this paragraph are not considered compensation if paid after severance from employment, even if they are paid within 2 1/2 months following severance from employment, except for payments to the individual who does not currently perform services for the employer by reason of qualified military service (within the meaning of Section 414(u)(1) of the Internal Revenue Code) to the extent these payments do not exceed the amounts the individual would have received if the individual had continued to perform services for the employer rather than entering qualified military service.

(D) An employee who is in qualified military service (within the meaning of Section 414(u)(1) of the Internal Revenue Code) shall be treated as receiving compensation from the employer during such period of qualified military service equal to (i) the compensation the employee would have received during such period if the employee were not in qualified military service, determined based on the rate of pay the employee would have received from the employer but for the absence during the period of qualified military service, or (ii) if the compensation the employee would have received during such period was not reasonably certain, the employee's average compensation from the employer during the twelve (12) month period immediately preceding the qualified military service (or, if shorter, the period of employment immediately preceding the qualified military service).

(E) Back pay, within the meaning of Treasury Regulation Section 1.415(c)-2(g)(8), shall be treated as compensation for the limitation year to which the back pay relates to the extent the back pay represents wages and compensation that would otherwise be included under this definition.

(4) For limitation years beginning on or after January 1, 2009, a member's compensation for purposes of subsection (k) shall not exceed the annual limit under Section 401(a)(17) of the Internal Revenue Code.

(I) **Service purchases under Section 415(n).**

(1) Effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, if a member makes one or more contributions to purchase permissive service credit under the plan, then the requirements of Section 415(n) of the Internal Revenue Code will be treated as met only if:

(A) The requirements of Section 415(b) of the Internal Revenue Code are met, determined by treating the accrued benefit derived from all such contributions as an annual benefit for purposes of Section 415(b) of the Internal Revenue Code, or

(B) the requirements of Section 415(c) of the Internal Revenue Code are met, determined by treating all such contributions as annual additions for purposes of Section 415(c) of the Internal Revenue Code.

(2) For purposes of applying this section, the system will not fail to meet the reduced limit under Section 415(b)(2)(C) of the Internal Revenue Code solely by reason of this paragraph and will not fail to meet the percentage limitation under Section 415(c)(1)(B) of the Internal Revenue Code solely by reason of this section.

(3) For purposes of this section the term "permissive service credit" means service credit:

(A) Recognized by the system for purposes of calculating a member's benefit under the system,

(B) which such member has not received under the system, and

(C) which such member may receive only by making a voluntary additional contribution, in an amount determined under the system, which does not exceed the amount necessary to fund the benefit attributable to such service credit. Effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, such term may include service credit for periods for which there is no performance of service, and, notwithstanding subparagraph (B) of this paragraph, may include service credited in order to provide an increased benefit for service credit which a member is receiving under the system.

(4) The system will fail to meet the requirements of this section if:

(A) more than five (5) years of nonqualified service credit are taken into account for purposes of this paragraph, or

(B) any nonqualified service credit is taken into account under this paragraph before the member has at least five (5) years of participation under the system.

(5) For purposes of paragraph (4) of this subsection, effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, the term "nonqualified service credit" means permissive service credit other than that allowed with respect to:

(A) Service (including parental, medical, sabbatical, and similar leave) as an employee of the Government of the United States, any State or political subdivision thereof, or any agency or instrumentality of any of the foregoing (other than military service or service for credit which was obtained as a result of a repayment described in Section 415(k)(3) of the Internal Revenue Code),

(B) service (including parental, medical, sabbatical, and similar leave) as an employee (other than as an employee described in subparagraph (A) of this paragraph) of an education organization described in Section 170(b)(1)(A)(ii) of the Internal Revenue Code which is a public, private, or sectarian school which provides elementary or secondary education (through grade 12), or a comparable level of education, as determined under the applicable law of the jurisdiction in which the service was performed,

(C) service as an employee of an association of employees who are described in subparagraph (A) of this paragraph, or

(D) military service (other than qualified military service under Section 414(u) of the Internal Revenue Code) recognized by the system.

(6) In the case of service described in subparagraphs (A), (B), or (C) of paragraph (5) of this subsection, such service will be nonqualified service if recognition of such service would cause a member to receive a retirement benefit for the same service under more than one plan.

(7) In the case of a trustee-to-trustee transfer after December 31, 2001, to which Section 403(b)(13)(A) of the Internal Revenue Code or Section 457(e)(17)(A) of the Internal Revenue Code applies (without regard to whether the transfer is made between plans maintained by the same employer):

(A) The limitations of paragraph (4) of this subsection will not apply in determining whether the transfer is for the purchase of permissive service credit, and

(B) the distribution rules applicable under federal law to the system will apply to such amounts and any benefits attributable to such amounts.

(8) For an eligible member, the limitation of Section 415(c)(1) of the Internal Revenue Code shall not be applied to reduce the amount of permissive service credit which may be purchased to an amount less than the amount which was allowed to be purchased under the terms of a Plan as in effect on August 5, 1997. For purposes of this paragraph an eligible member is an individual who first became a member in the system before January 1, 1998.

(m) **Modification of contributions for 415(c) and 415(n) purposes.** Notwithstanding any other provision of law to the contrary, the system may modify a request by a member to make a contribution to the system if the amount of the contribution would exceed the limits provided in Section 415 of the Internal Revenue Code by using the following methods:

(1) If the law requires a lump sum payment for the purchase of service credit, the system may establish a periodic payment plan for the member to avoid a contribution in excess of the limits under Section 415(c) or 415(n) of the Internal Revenue Code.

(2) If payment pursuant to paragraph (1) of this subsection will not avoid a contribution in excess of the limits imposed by Section 415(c) or 415(n) of the Internal Revenue Code, the system may either reduce the member's contribution to an amount within the limits of those sections or refuse the member's contribution.

(n) **Repayments of cashouts.** Any repayment of contributions (including interest thereon) to the plan with respect to an amount previously refunded upon a forfeiture of service credit under the plan or another governmental plan maintained by the retirement system shall not be taken into account for purposes of Section 415 of the Internal Revenue Code, in accordance with applicable Treasury Regulations.

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(o) **Reduction of benefits priority.** Reduction of benefits and/or contributions to all plans, where required, shall be accomplished by first reducing the member's benefit under any defined benefit plans in which the member participated, such reduction to be made first with respect to the plan in which the member most recently accrued benefits and thereafter in such priority as shall be determined by the plan and the plan administrator of such other plans, and next, by reducing or allocating excess forfeitures for defined contribution plans in which the member participated, such reduction to be made first with respect to the plan in which the member most recently accrued benefits and thereafter in such priority as shall be established by the plan and the plan administrator for such other plans provided, however, that necessary reductions may be made in a different manner and priority pursuant to the agreement of the plan and the plan administrator of all other plans covering such member.

590:15-1-12. Rollovers

~~A distributee may elect to have eligible rollover distributions paid in a direct rollover to an eligible retirement plan the distributee specifies, pursuant to Section 401(a)(31) of the federal Internal Revenue Code.~~

(a) For purposes of compliance with Section 401(a)(31) of the Internal Revenue Code, this section applies notwithstanding any contrary provision or retirement law that would otherwise limit a distributee's election to make a rollover. A distributee may elect, at a time and in the manner prescribed by the Board of Trustees, to have any portion of an eligible rollover distribution paid directly to an eligible retirement plan specified by the distributee in a direct rollover.

(b) "Eligible rollover distribution" means any distribution of all or any portion of the balance to the credit of the distributee, except that an eligible rollover distribution does not include: any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or the life expectancy) of the distributee or the joint lives (or joint life expectancies) of the distributee and the distributee's designated beneficiary, or for a specified period of ten years or more; any distribution to the extent such distribution is required under Section 401(a)(9) of the Internal Revenue Code; the portion of any distribution that is not includible in gross income; and any other distribution that is reasonably expected to total less than Two Hundred Dollars (\$200.00) during the year. Effective January 1, 2002, the definition of eligible rollover distribution also includes a distribution to a surviving spouse or to a spouse or former spouse who is an alternate payee under a qualified domestic relations order, as defined in Section 414(p) of the Internal Revenue Code.

(c) Effective January 1, 2002, a portion of a distribution will not fail to be an eligible rollover distribution merely because the portion consists of after-tax employee contributions that are not includible in gross income. However, such portion may be transferred only:

(1) To an individual retirement account or annuity described in Section 408(a) or (b) of the Internal Revenue Code or to a qualified defined contribution plan described in Section 401(a) of the Internal Revenue Code;

(2) on or after January 1, 2007, to a qualified defined benefit plan described in Section 401(a) of the Internal Revenue Code or to an annuity contract described in Section 403(b) of the Internal Revenue Code, that agrees to separately account for amounts so transferred (and earnings thereon), including separately accounting for the portion of the distribution that is includible in gross income and the portion of the distribution that is not so includible;

or
(3) on or after January 1, 2008, to a Roth IRA described in Section 408A of the Internal Revenue Code.

(d) "Eligible retirement plan" means any of the following that accepts the distributee's eligible rollover distribution:

(1) An individual retirement account described in Section 408(a) of the Internal Revenue Code,

(2) an individual retirement annuity described in Section 408(b) of the Internal Revenue Code,

(3) an annuity plan described in Section 403(a) of the Internal Revenue Code,

(4) a qualified trust described in Section 401(a) of the Internal Revenue Code,

(5) effective January 1, 2002, an annuity contract described in Section 403(b) of the Internal Revenue Code,

(6) effective January 1, 2002, a plan eligible under Section 457(b) of the Internal Revenue Code that is maintained by a state, political subdivision of a state, or any agency or instrumentality of a state or a political subdivision of a state that agrees to separately account for amounts transferred into that plan from the retirement system, or

(7) effective January 1, 2008, a Roth IRA described in Section 408A of the Internal Revenue Code.

(e) "Distributee" means an employee or former employee. It also includes the employee's or former employee's surviving spouse and the employee's or former employee's spouse or former spouse who is the alternate payee under a qualified domestic relations order, as defined in Section 414(p) of the Internal Revenue Code. Effective January 1, 2007, a distributee further includes a non-spouse beneficiary who is a designated beneficiary as defined by Section 401(a)(9)(E) of the Internal Revenue Code. However, a non-spouse beneficiary may rollover the distribution only to an individual retirement account or individual retirement annuity established for the purpose of receiving the distribution, and the account or annuity will be treated as an "inherited" individual retirement account or annuity.

(f) "Direct rollover" means a payment by the plan to the eligible retirement plan specified by the distributee.

590:15-1-18. Federal qualified military service rights

(a) **Additional benefits if provided by Plan.** Effective with respect to deaths occurring on or after January 1, 2007, while a member is performing qualified military service (as defined in Chapter 43 of Title 38, United States Code), to the extent required by Section 401(a)(37) of the Internal Revenue Code,

survivors of a member in a State or local retirement or pension system, are entitled to any additional benefits that the system would otherwise provide if the member had resumed employment and then died, such as accelerated vesting or survivor benefits that are contingent on the member's death while employed.

(b) **Differential wage payments.** Beginning January 1, 2009, to the extent required by Sections 3401(h) and 414(u)(2) of the Internal Revenue Code, an individual receiving differential wage payments (while the individual is performing qualified military service as defined in Chapter 43 of Title 38, United States Code) from an employer shall be treated as employed by that employer and the differential wage payment shall be treated as earned compensation. This provision shall be applied to all similarly situated individuals in a reasonably equivalent manner.

590:15-1-19. Actuarial assumptions

Effective as of July 1, 1989, the Board will determine the amount of any benefit that is determined on the basis of actuarial assumptions using assumptions adopted by the Board of Trustees by resolution. Such benefits will not be subject to employer discretion. The resolutions adopted by the Board of Trustees for this purpose are incorporated as part of the plan document.

590:15-1-20. Employee contributions vested; forfeiture

(a) **Vesting of contributions.** A plan member shall be one hundred percent (100%) vested in his or her accumulated contributions at all times in compliance with Section 401(a)(7) of the Internal Revenue Code.

(b) **Forfeitures under Internal Revenue Code.** In conformity with section 401(a)(8) of the Internal Revenue Code, any forfeitures of benefits by members or former members of the plan will not be used to pay benefit increases. However, such forfeitures shall be used to reduce employer contributions.

590:15-1-21. Required minimum distributions

(a) The retirement system will pay all benefits in accordance with a good faith interpretation of the requirements of Section 401(a)(9) of the Internal Revenue Code and the regulations in effect under that section, as applicable to a governmental plan within the meaning of Section 414(d) of the Internal Revenue Code. The retirement system is subject to the following provisions:

(1) Distribution of a member's benefit must begin by the required beginning date, which is the later of the April 1 following the calendar year in which the member attains age 70 1/2 or April 1 of the year following the calendar year in which the member terminates. If a member fails to apply for retirement benefits by the later of either of those dates, the Board shall begin distribution of the monthly benefit as required by this rule in the form provided in 20 O.S. §1101 et seq.

(2) The member's entire interest must be distributed over the member's life or the lives of the member and a

designated beneficiary, or over a period not extending beyond the life expectancy of the member or of the member and a designated beneficiary.

(3) If a member dies after the required distribution of benefits has begun, the remaining portion of the member's interest must be distributed at least as rapidly as under the method of distribution before the member's death.

(4) If a member dies before required distribution of the member's benefits has begun, the member's entire interest must be either:

(A) Distributed (in accordance with federal regulations) over the life or life expectancy of the designated beneficiary, with the distributions beginning no later than December 31 of the calendar year following the calendar year of the member's death (or, if the designated beneficiary is the member's surviving spouse, beginning no later than the date on which the member would have attained age 70 1/2), or

(B) distributed within five (5) years of the member's death.

(5) The amount of an annuity paid to a member's beneficiary may not exceed the maximum determined under the incidental death benefit requirement of Section 401(a)(9)(G) of the Internal Revenue Code, and the minimum distribution incidental benefit rule under Treasury Regulation Section 1.401(a)(9)-6, Q&A-2.

(6) The death and disability benefits provided by the retirement system are limited by the incidental benefit rule set forth in Section 401(a)(9)(G) of the Internal Revenue Code and Treasury Regulation Section 1.401-1(b)(1)(i) or any successor regulation thereto. As a result, the total death or disability benefits payable may not exceed twenty-five percent (25%) of the cost for all of the members' benefits received from the retirement system.

(b) Notwithstanding the other provisions of this rule or the provisions of the Treasury Regulations, benefit options may continue so long as the option satisfies Section 401(a)(9) of the Internal Revenue Code based on a reasonable and good faith interpretation of that section.

[OAR Docket #10-445; filed 3-29-10]

TITLE 590. OKLAHOMA PUBLIC EMPLOYEES RETIREMENT SYSTEM CHAPTER 25. DEFERRED COMPENSATION

[OAR Docket #10-446]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 3. Election to Defer Compensation 590:25-3-1. Election limits [AMENDED]
- Subchapter 9. Benefits 590:25-9-17. Rollovers to other plans [AMENDED]
- 590:25-9-20. Qualified military service [NEW]

AUTHORITY:

Oklahoma Public Employees Retirement System Board of Trustees; 74 O.S. § 1701 et seq.

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ANALYSIS:

The amendment to 590:25-3-1 modifies what is considered compensation for purpose of deferred compensation election limits.

The amendment to 590:25-9-17 modifies the type of eligible rollover distributions that are permitted under the Internal Revenue Code.

The addition of 590:25-9-20 is added as a result of the federal Uniformed Services Employment and Reemployment Rights Act of 1994 and the Heroes Earnings Assistance and Relief Act of 2008. This rule relates to certain federal rights available to members with qualified military service.

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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 MAY 13, 2010:

SUBCHAPTER 3. ELECTION TO DEFER COMPENSATION

590:25-3-1. Election limits

(a) The Employee may elect to participate in this Plan and consent to the Employer, deferring a predetermined amount equivalent to at least Twenty-Five Dollars (\$25.00) a month. Effective January 1, 2002, the maximum that may be deferred under the Plan for the taxable year shall not exceed the lesser of the maximum amount allowed each year as determined by the Internal Revenue Service or one hundred percent (100%) of the employee's includable compensation. For purposes of the Plan, only compensation from the Employer that is attributable to services performed for Employer may be includable in gross income. Compensation includes payments made by the later of 2 1/2 months after severance from employment or the end of the calendar year that includes the date of the Participant's severance from employment if they are payments that, absent a severance from employment, would have been paid had the

Participant continued in employment with the Employer and are:

(1) Regular compensation for services during the Participant's regular working hours, or compensation for services outside the Employee's regular work hours (such as overtime or shift differential), commissions, bonuses, or other similar payments, and the compensation would have been paid to the Participant prior to a severance from employment if the Participant had continued employment with the Employer; or

(2) payments for unused accrued bona fide sick, vacation or other leave, but only if the Participant would have been able to use the leave if employment had continued; or

(3) payments pursuant to a nonqualified unfunded deferred compensation plan, but only if the payments would have been paid to the Qualified Participant at the same time if the Participant had continued employment with the Employer and only to the extent that the payment is includible in the Qualified Participant's gross income.

(b) Includable compensation excludes amounts converted under the State's Internal Revenue Code Section 125 Plan and employee retirement contributions that are tax-deferred. The deferment will commence no sooner than the first pay period of the month following the date the enrollment application is properly completed by the Employee and accepted by the Plan Administrator.

SUBCHAPTER 9. BENEFITS

590:25-9-17. Rollovers to other plans

(a) Effective January 1, 2002, notwithstanding any provisions of the Plan to the contrary that would otherwise limit a distributee's election under this Section, a distributee may elect to have any portion of an eligible rollover distribution paid directly to an eligible retirement plan specified by the distributee in a direct rollover.

(b) As used in this section:

(1) "Eligible retirement plan", for purposes of a direct rollover, shall mean a qualified trust described in ~~section Section~~ Section 401(a) of the Code, an annuity plan described in section 403(a) of the Code, an individual retirement account described in section Section 408(a) of the Code, an individual retirement annuity described in section Section 408(b) of the Code, or a Roth individual annuity (if the individual is eligible for a Roth rollover) described in Section 408(A)(e) for distributions made after December 31, 2007, that accepts the distributee's eligible rollover distribution. However, in the case of an eligible rollover distribution to the surviving spouse, an eligible retirement plan is an individual retirement account or individual retirement annuity. Effective for distributions made after December 31, 2001, an eligible retirement plan shall also mean an annuity contract described in ~~section Section~~ Section 403(b) of the Code and an eligible plan under section Section 457(b) of the Code which is maintained by a state, political subdivision of a state, or any agency or

instrumentality of a state or political subdivision of a state and which agrees to separately account for amounts transferred into such plan from this ~~plan~~ Plan. The definition of eligible retirement plan shall also apply in the case of a distribution to a surviving spouse, or to a spouse or former spouse who is the alternate payee under a qualified domestic relations order, as defined in Section 414(p) of the Code.

(2) "Eligible rollover distribution" means any distribution of all or any portion of the balance to the credit of the distributee, except that an eligible rollover distribution does not include (i) any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the distributee or the joint lives (or joint life expectancies) of the distributee and the designated beneficiary of the distributee, or for a specified period of ten (10) years or more; (ii) any distribution to the extent such distribution is required under ~~Code~~ Section 401(a)(9) of the Code; (iii) the portion of any distribution that is not includable in gross income (determined without regard to the exclusion for net unrealized appreciation with respect to employer securities); or (iv) any amount that is distributed on account of hardship.

(3) "Distributee" includes a Participant or a Participant's surviving spouse, or for the limited purposes set forth in paragraph (c) of this section, a non-spouse beneficiary.

(c) Effective January 1, 2007, a non-spouse beneficiary pursuant to ~~section~~ Section 402(c)(11) of the Code may elect to have any portion of an eligible rollover distribution paid directly to an individual retirement account described in ~~section~~ Section 408(a) of the Code, or an individual retirement annuity described in ~~section~~ Section 408(b) of the Code, established for the purpose of receiving the distribution. A rollover pursuant to this paragraph shall be treated as a rollover of an eligible rollover distribution only for purposes of ~~section~~ Section 402(c) of the Code.

(d) Except as otherwise provided, this section shall apply to distributions made after December 31, 2001.

590:25-9-20. Federal qualified military service

Notwithstanding any provisions of this Plan to the contrary, contributions, benefits, and service credit with respect to qualified military service shall be provided in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), the Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART"), and Section 414(u) of the Code.

(1) A Qualified Participant whose employment is interrupted by qualified military service under Section 414(u) of the Code or who is on a leave of absence for qualified military service under Section 414(u) may elect to make additional deferrals to the Plan upon resumption of employment with the Employer equal to the maximum annual deferrals that the Participant could have elected during that period if the Participant's employment with the Employer

had continued (at the same level of Compensation) without the interruption or leave, reduced by the annual deferrals, if any, actually made for the Participant during the period of the interruption or leave. This right applies to five (5) years following the resumption of employment, if sooner, for a period equal to three times the period of the interruption or leave. The Employer, in accordance with 74 O.S. §1701, will make the Employer Contribution for such Qualified Participant for the equivalent period.

(2) Effective January 1, 2009, a Qualified Participant whose employment is interrupted by qualified military service or who is on a leave of absence for qualified military service and who receives a differential wage payment within the meaning of Section 414(u)(12)(D) of the Code from the Employer, will be treated as a Participant of the Employer and the differential wage payment will be treated as Compensation.

(3) Effective January 1, 2007, death benefits payable under this Plan shall be paid in accordance with Section 401(a)(37) of the Code, which provides that in the case of a Participant who dies while performing qualified military service (as defined in Section 414(u) of the Code), the survivors of the Participant are entitled to any additional benefits (other than benefit accruals relating to the period of qualified military service) that the Plan would otherwise provide had had the Participant resumed and then terminated employment with the Employer on account of death.

[OAR Docket #10-446; filed 3-29-10]

**TITLE 590. OKLAHOMA PUBLIC EMPLOYEES RETIREMENT SYSTEM
CHAPTER 35. DEFERRED SAVINGS INCENTIVE PLAN**

[OAR Docket #10-447]

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PERMANENT final adoption

RULES:

Subchapter 7. Contributions

590:35-7-1. Employer contributions [AMENDED]

Subchapter 13. Benefits and Distributions

590:35-13-9. Rollovers to eligible retirement plan [AMENDED]

Subchapter 15. Limitations on Annual Additions

590:35-15-2. Definitions [AMENDED]

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ANALYSIS:

The amendment to 590:35-7-1 clarifies how contributions, benefits and service credit for qualified military service is accounted for under the federal Uniformed Services Employment and Reemployment Rights Act of 1994 and the Heroes Earnings Assistance and Relief Act of 2008. This rule relates to certain federal rights available to members with qualified military service.

The amendment to 590:35-13-9 modifies the definition of eligible retirement plan for purposes of rollover distributions to include a Roth individual annuity in accordance with the Internal Revenue Code.

The amendment to 590:35-15-2 modifies the definition of compensation to provide for certain payments made after severance from employment. This amendment complies with federal tax laws.

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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 MAY 13, 2010:

SUBCHAPTER 7. CONTRIBUTIONS

590:35-7-1. Employer contributions

(a) The Employer shall contribute to the Trust Fund an amount referred to as an Employer Contribution. Such contribution shall be calculated as follows: in accordance with ~~Section 1707 of Title 74 of the Oklahoma Statutes, 74 O.S. §1707,~~ a contribution in the amount of or equivalent to ~~twenty five dollars~~ Twenty-Five Dollars (\$25.00) per month, or such amount as may be appropriated by the Legislature of the State of Oklahoma shall be made to the Plan on behalf of each Qualified Participant, as soon as practicable after receipt.

(b) Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service will be provided in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), the Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART"), and Code Section 414(u) of the Internal Revenue Code.

(1) Effective January 1, 2009, a Qualified Participant whose employment is interrupted by qualified military service or who is on a leave of absence for qualified military service and who receives a differential wage payment within the meaning of Section 414(u)(12)(D) of the Internal Revenue Code from the Employer, will be treated as a Participant of the Employer and the differential wage payment will be treated as Compensation.

(2) Effective January 1, 2007, death benefits payable under this Plan shall be paid in accordance with Section 401(a)(37) of the Internal Revenue Code, which provides that in the case of a Participant who dies while performing qualified military service (as defined in Section 414(u) of the Internal Revenue Code), the survivors of the Participant are entitled to any additional benefits (other than benefit accruals relating to the period of qualified military service) that the Plan would otherwise provide had the Participant resumed and then terminated employment with the Employer on account of death.

SUBCHAPTER 13. BENEFITS AND DISTRIBUTIONS

590:35-13-9. Rollovers to eligible retirement plan

(a) Notwithstanding any provision of the Plan to the contrary that would otherwise limit a distributee's election under this Section, a distributee may elect, at the time and in the manner prescribed by the Plan Administrator, to have any portion of an eligible rollover distribution paid directly to an eligible retirement plan specified by the distributee in a direct rollover.

(b) As used in this section:

(1) "Eligible rollover distribution" means any distribution of all or any portion of the balance to the credit of the distributee, except that an eligible rollover distribution does not include: any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the distributee or the joint lives (or joint life expectancies) of the distributee and the distributee's designated beneficiary, or for a specified period of ten years or more; any distribution to the extent such distribution is required under Code Section 401(a)(9); the portion of any other distribution(s) that is not includible in gross income, except to the extent provided by paragraph (c) of this section; and effective for distributions made after December 31, 2001, any amount that is distributed on account of hardship shall not be an eligible rollover distribution and the distributee may not elect to have any portion of such a distribution paid directly to an eligible retirement plan.

(2) "Eligible retirement plan" means an individual retirement account described in Code Section 408(a), an individual retirement annuity described in Code Section 408(b), or a qualified trust described in Code Section 401(a), or Roth individual annuity (if the individual is eligible for a Roth rollover) described in Code Section 408(A)(e) for distributions made after December 31, 2007, that accepts the distributee's eligible rollover distribution. However, in the case of an eligible rollover distribution to the surviving spouse, an eligible retirement plan is an individual retirement account or individual retirement annuity. Effective for distributions made after December 31, 2001, an eligible retirement plan shall also mean an annuity contract described in Code Section 403(b) and an eligible plan under Code Section 457(b) which is maintained by a state, political subdivision of a

state, or any agency or instrumentality of a state or political subdivision of a state and which agrees to separately account for amounts transferred into such plan from this Plan. The definition of eligible retirement plan shall also apply in the case of a distribution to a surviving spouse, or to a spouse or former spouse who is the alternate payee under a qualified domestic relation order, as defined in Code Section 414(p).

(3) "Distributee" means a Participant. In addition, the Participant or the Participant's surviving spouse are distributees with regard to the interest of the spouse. For the limited purposes set forth in paragraph (d) of this section, distributee means a non-spouse beneficiary.

(4) "Direct rollover" means a payment by the Plan to the eligible retirement plan specified by the distributee.

(c) A portion of a distribution shall not fail to be an eligible rollover distribution merely because the portion consists of after-tax employee contributions which are not includible in gross income. However, such a portion may be transferred only to an individual retirement account or an individual retirement annuity described in section Code Section 408(a) or (b) of the Code, a qualified plan described in section Code Sections 401(a) or 403(a) of the Code, or to an annuity contract described in section Code Section 403(b) of the Code that agrees to separately account for amounts so transferred, including separately accounting for the portion of such distribution which is includible in gross income and the portion of such distribution which is not so includible.

(d) Effective January 1, 2007, a non-spouse beneficiary pursuant to section Code Section 402(c)(11) of the Code may elect to have any portion of an eligible rollover distribution paid directly to an individual retirement account described in section Code Section 408(a) of the Code, or an individual retirement annuity described in section Code Section 408(b) of the Code, established for the purpose of receiving the distribution. A rollover pursuant to this paragraph shall be treated as a rollover of an eligible rollover distribution only for purposes of section Code Section 402(c) of the Code.

SUBCHAPTER 15. LIMITATIONS ON ANNUAL ADDITIONS

590:35-15-2. Definitions

The following words or terms, when used in this Subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"**Annual addition**" means the sum for any Plan year of the following amounts allocated on behalf of a Qualified Participant for a Limitation Year:

- (A) All Employer contributions;
- (B) All Qualified Participant contributions determined without regard to any rollover contributions (as defined in Code Sections 402(c), 403(a)(4), 403(b)(8), and 408(d)(3)) without regard to Qualified Participant contributions to a simplified employee pension which are excludable from gross income under Code Section 408(k)(6);

- (C) All forfeitures;
- (D) Amounts allocated to an individual medical account, as defined in Code Section 415(l)(2), which is part of a pension or annuity plan maintained by the Employer; and

(E) Amounts derived from contributions which are attributable to post-retirement benefits allocated to the separate account of a key employee, as defined in Code Section 419A(d)(3), under a welfare benefit fund, as defined in Code Section 419(e), maintained by the Employer. Subparagraph (ii) of Section 590:35-15-1 shall not apply to any contribution for medical benefits (within the meaning of Code Section 419A(f)(2)) after separation from service which is treated as an Annual addition. For purposes of this Subchapter, excess amounts reapplied to reduce Employer contributions under Section 590:-15-3 in the Limitation Year shall also be included as an Annual Addition for such Limitation Year.

"**Compensation**" means:

(A) ~~for~~ For purposes of applying the limitation of Code Section 415, ~~means~~—a Qualified Participant's wages, salaries, fees for professional services, and other amounts received (without regard to whether or not an amount is paid in cash) for personal services actually rendered in the course of employment with the Employer maintaining this Plan to the extent that the amounts are includable in gross income (including, but not limited to, commissions paid salesmen, compensation for services on the basis of a percentage of profits, commissions on insurance premiums, tips, bonuses, fringe benefits, and reimbursements or other expense allowances under a nonaccountable plan (as described in Treasury Regulation Section 1.62-2(c)), and excluding the following:

(A_i) Distributions from a plan of deferred compensation, regardless of whether such amounts are includable in the gross income of the Qualified Participant when distributed; and

(B_{ii}) ~~Other~~ other amounts which receive special tax benefits, such as premiums for group-term life insurance (but only to the extent that the premiums are not includable in the gross income of the Qualified Participant). Compensation shall also include contributions made pursuant to a salary reduction agreement which are not includable in the gross income of the Qualified Participant under Code Sections 125, 132(f)(4), 401(k), 408(k), 403(b) or 457. For purposes of applying the limitation of this Subchapter, Compensation for a Limitation Year is the Compensation actually paid or made available to the Qualified Participant within the Limitation Year. Notwithstanding the preceding sentence, Compensation for a Qualified Participant who is permanently and totally disabled (as defined in Code Section 22(e)(3)) is the Compensation such Qualified Participant would have received

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for the Limitation Year if such Qualified Participant had been paid at the rate of Compensation paid immediately before becoming permanently and totally disabled. If the Plan provides for the continuation of such contributions on behalf of all Qualified Participants who are permanently and totally disabled for a fixed or determinable period, then imputed Compensation may be taken into account for a disabled Qualified Participant, ~~who is a "highly compensated employee" (as defined in Code Section 414(q)), as well as for a disabled Qualified Participant who is not a "highly compensated employee."~~ Such contributions on behalf of a permanently and totally disabled Qualified Participant must be nonforfeitable when made.

(B) Payments made by the later of 2 1/2 months after severance from employment or the end of the limitation year that includes the date of the Qualified Participant's severance from employment shall be included in compensation if they are payments that, absent a severance from employment, would have been paid to the Qualified Participant while the Qualified Participant continued in employment with the Employer and are:

- (i) Regular compensation for services during the Qualified Participant's regular working hours, or compensation for services outside the Participant's regular work hours (such as overtime or shift differential), commissions, bonuses, or other similar payments, and the compensation would have been paid to the Participant prior to a severance from employment if the Participant had continued employment with the Employer; or
- (ii) payments for unused accrued bona fide sick, vacation or other leave, but only if the Qualified Participant would have been able to use the leave if employment had continued; or
- (iii) payments pursuant to a nonqualified unfunded deferred compensation plan, but only if the payments would have been paid to the Qualified Participant at the same time if the Participant had continued employment with the Employer and only to the extent that the payment is includible in the Qualified Participant's gross income.

(C) Any payments not described in paragraph (B) of this definition are not considered compensation if paid after severance from employment, even if they are paid within 2 1/2 months following severance from employment. However, payments to the individual who does not currently perform services for the Employer by reason of qualified military service (within the meaning of Code Section 414(u)(1)) to the extent these payments do not exceed the amounts the individual would have received if the individual had continued to perform services for the Employer rather than entering qualified military service.

(D) An employee who is in qualified military service (within the meaning of Code Section 414(u)(1))

shall be treated as receiving compensation from the employer during such period of qualified military service equal to:

- (i) the compensation the employee would have received during such period if the employee were not in qualified military service, determined based on the rate of pay the employee would have received from the employer but for the absence during the period of qualified military service, or
- (ii) if the compensation the employee would have received during such period was not reasonably certain, the employee's average compensation from the employer during the twelve month period immediately preceding the qualified military service (or, if shorter, the period of employment immediately preceding the qualified military service).

(E) For purposes of Code Section 415(c) and this subchapter, compensation of each Participant taken into account in determining allocations for any Plan Year shall not exceed the applicable limit established by Code Section 401(a)(17) as of the first day of the Plan Year, as increased for the cost-of-living adjustment (Two Hundred Thirty Thousand Dollars (\$230,000 for 2008)). The cost-of-living adjustment in effect for a calendar year applies to compensation for the Plan Year that begins with or within such calendar year.

"Employer" means, for purposes of this Subchapter, the Employer and all members of a controlled group of corporations (as defined in Code Section 414(b) and as modified by Code Section 415(h)), all commonly controlled trades or businesses (as defined in Code Section 414(c) and as modified by Code Section 415(h)), or an affiliated service group (as defined in Code Section 414(m)), of which the adopting Employer is a part, and any other entity required to be aggregated with the Employer pursuant to Treasury Regulations under Code Section 414(o).

"Limitation year" means the Plan Year ending on December 31.

[OAR Docket #10-447; filed 3-29-10]

TITLE 775. OKLAHOMA BOARD OF VETERINARY MEDICAL EXAMINERS CHAPTER 10. LICENSURE OF VETERINARIANS, VETERINARY TECHNICIANS AND ANIMAL EUTHANASIA TECHNICIANS

[OAR Docket #10-464]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Licensure of Veterinarians

775:10-3-12 [AMENDED]

Subchapter 8. Certification of Euthanasia Technicians

775:10-8-2 [AMENDED]

- 775:10-8-3 [AMENDED]
- 775:10-8-4 [AMENDED]
- 775:10-8-5 [AMENDED]
- 775:10-8-6 [AMENDED]
- 775:10-8-7 [AMENDED]
- 775:10-8-10 [AMENDED]
- 775:10-8-11 [AMENDED]
- 775:10-8-12 [AMENDED]
- 775:10-8-14 [AMENDED]
- 775:10-8-15 [AMENDED]
- 775:10-8-16 [AMENDED]
- 775:10-8-17 [AMENDED]
- 775:10-8-21 [AMENDED]
- 775:10-8-24 [AMENDED]
- 775:10-8-25 [AMENDED]
- 775:10-8-26 [AMENDED]
- 775:10-8-27 [AMENDED]
- 775:10-8-28 [AMENDED]
- 775:10-8-29 [AMENDED]
- 775:10-8-30 [AMENDED]
- 775:10-8-32 [REVOKED]
- 775:10-8-33 [REVOKED]
- 775:10-8-34 [REVOKED]

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59 O.S. Supp.2009, SEC. 698.1 et seq.; Board of Veterinary Medical Examiners

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N/A

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

The permanent new rules are to reference the statutory authority regarding the reactivation fee. Additionally, the Euthanasia Rules need a complete renovation to eliminate duplicative language already in the Veterinary Practice Act. Also, the Euthanasia technicians are governed by the Bureau of Narcotics and Dangerous Drugs and they have rules in place the Euthanasia technician must follow.

CONTACT PERSON:

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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 JULY 1, 2010:

SUBCHAPTER 3. LICENSURE OF VETERINARIANS

775:10-3-12. Fees

(a) Fee Schedule.

(1) **Examination.** The following fees shall be assessed for licensure and examination of veterinarians:

(A) North American Veterinary Licensing Examination - At Cost + \$185.00

(B) Oklahoma State Examination - \$150.00

(2) **Licensure.** The following fees shall be assessed for licensure of veterinarians:

(A) Annual renewal (prior to June 30) - \$225.00

(B) Annual renewal Faculty License (prior to July 15) - \$175.00

(C) Reactivation fee (between July 1 and August 29 as referenced in the Act 698.10a(D)) - \$275.00

(D) Reinstatement fee (after August 30) - \$625.00

(E) Licensure by Endorsement - \$625.00

(F) Faculty License - \$125.00

(3) **Duplication or modification of license.** A fee of \$50.00 shall be assessed for duplication or modification of a veterinary license.

(4) **Supervised Doctor of Veterinary Medicine.** The following fees shall be assessed for certification as a supervised doctor of veterinary medicine:

(A) Original Certificate - \$125.00

(B) Extension - \$100.00

(C) Transfer - \$50.00

(5) **Miscellaneous fees.** The following miscellaneous fees shall be assessed by the Board.

(A) Certification of scores - \$40.00

(B) Verification of license - \$20.00

(C) Duplication of proof of renewal of license - \$10.00

(D) Certification of public records (per page) - \$1.00

(E) Duplication of public records (per page) - \$.25

(F) Transcript of public records recorded (per page) - At Cost

(G) Issuance of subpoena - \$.25

(H) Returned check processing fee - \$35.00

(I) Probation fees:

(i) \$50.00/month, unless otherwise modified by the Board or the Secretary/Treasurer

(ii) Investigation/Prosecution - at cost (Non-payment of investigation, prosecution or probation costs or fees within 30 days of billing may be grounds for imposition of additional sanctions by the Board).

(J) Declaratory ruling - \$300.00 plus costs.

(K) Continuing education extension fee - \$100.00 (active military exempt)

(6) **Registered Veterinary technician fees.** The following registered veterinary technician fees shall be assessed by the Board:

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- (A) National Veterinary Technician Examination - at cost
 - (B) State Examination - \$60.00
 - (C) Application Processing Fee - \$50.00
 - (D) Certificate - \$20.00
 - (E) Annual Renewal - \$45.00
- (7) **Animal Euthanasia technician fees.** The following animal euthanasia technician fees shall be assessed by the Board:
- (A) Training and Practical Examination - At cost
 - (B) Oklahoma State Bureau of Investigation criminal history search - At cost
 - (C) State Written Examination - \$60.00
 - (D) Application Processing Fee - \$50.00
 - (E) Certificate - \$20.00
 - (F) Annual Renewal - \$40.00
 - (G) Reactivation fee - \$25.00
- (b) **Submission of fees.** All fees are non-refundable.

SUBCHAPTER 8. CERTIFICATION OF EUTHANASIA TECHNICIANS

775:10-8-2. Definitions

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

"Administer" means the direct application of a controlled dangerous substance, whether by injection, inhalation, ingestion or any other means, to the body of an animal.

"Animal" means any animal other than humans, whether wild or domestic, and includes, but is not limited to, mammals, birds, fish, and reptiles.

"Animal Control Agency" means a federal, state, county or municipal agency or an agency which is a political division or subdivision of a federal, state, county or municipal agency authorized by law with the duties of enforcing laws or ordinances relating to the licensure of animals, control of animals, or seizure and impoundment of animals, and includes any federal, state or local law enforcement agency which employs animal control officers, peace officers or other employees whose duties in whole or in part include assignments that involve the seizure and impoundment of any animal.

"Animal handler" means a person who is trained in techniques of animal handling and human safety and is not certified as an animal euthanasia technician.

"Animal Shelter" means a private animal shelter, humane society organization or wildlife rehabilitation facility, which is recognized and approved by the Board.

"Board" means the Oklahoma State Board of Veterinary Medical Examiners.

"Citizen complaint" means a written or oral statement of complaint from any person of a possible violation of the Veterinary Practice Act or implementing rules.

"Commercial container" means any container in which a controlled dangerous substance is packaged by the manufacturer or distributor and includes, but is not limited to, vials,

bottles and cartons. The term "commercial container" does not include package inserts, such as drug information.

"Committee" means the committee on animal euthanasia technicians.

"Complaint" means a written statement of alleged violation of the Veterinary Practice Act and/or implementing rules by a person or entity under the jurisdiction of the Board and which is filed with the Secretary-Treasurer in anticipation of the issuance of a citation. This definition is distinct from a citizen complaint.

"Controlled Dangerous Substance" means a drug, substance or immediate precursor in Schedules I through V of the Uniform Controlled Dangerous Substances Act, Section 2-101 et seq. of Title 63 of the Oklahoma Statutes.

"DEA" means the Drug Enforcement Administration.

"Denatured sodium pentobarbital" means sodium pentobarbital to which an agent has been added that makes it unsuitable for use other than for euthanasia of animals.

"Dispense" means to deliver a controlled dangerous substance to an ultimate user by or pursuant to the lawful order of a practitioner, including the prescribing, administering, packaging, labeling or compounding necessary to prepare the substance for such delivery.

"Dispose" or "disposal" means the physical delivery of a controlled dangerous substance to the OSBI, OBN or DEA for destruction.

"Employee" means an individual who is under wages or a salary, and where the employer has the power or right to control and direct the employee in the material details of how the work is to be performed. The term "Employee" does not include an individual providing services under contract.

"Euthanasia drug" means denatured sodium pentobarbital or other drug approved for animal euthanasia by the Board.

"Euthanasia Technician" means an employee of a law enforcement agency, an animal control agency, or animal shelter that is recognized and approved by the Board, who is certified by the Board and trained to administer sodium pentobarbital to euthanize injured, sick, homeless or unwanted domestic pets and other animals. This person may use the title "Certified Animal Euthanasia Technician (CAET)".

"Fiscal year" means the fiscal year of the Board, which is July 1 through June 30.

"Law Enforcement Agency" means a federal, state, county or municipal agency or other agency authorized by law with the duties to maintain public order, make arrests, serve warrants, and enforce the laws of the United States, this state, and county or municipal ordinances.

"Licensed veterinarian" means a veterinarian who holds an active license to practice veterinary medicine in this state.

"Mid-level practitioner" means an individual practitioner, other than a physician, dentist, veterinarian, or podiatrist, who is licensed, regulated, or otherwise permitted by the United States or the jurisdiction in which he/she practices, to dispense a controlled substance in the course of professional practice.

"Non-commercial container" means any container other than a commercial container which contains a controlled dangerous substance. A non-commercial container includes, but

is not limited to, vials, bottles, boxes or envelopes into which a controlled dangerous substance has been transferred from a commercial container.

"OAC" means the Oklahoma Administrative Code.

"OBN" means the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control.

"OSBI" means the Oklahoma State Bureau of Investigation.

"Primary container" means any container, whether commercial or non-commercial, which is in direct contact with a controlled dangerous substance, whether the substance is liquid, solid or encapsulated, and includes, but is not limited to, vials, bottles, boxes or envelopes.

"Regulations" means federal regulations as published in the Code of Federal Regulations and which are promulgated under and implement federal statutes.

"Rules" means the administrative rules as published in the Oklahoma Administrative Code and which are promulgated under and implement Oklahoma Statutes.

"Transfer" means the physical transfer of a controlled dangerous substance from one individual registered with the OBN and DEA to another individual registered with the OBN and DEA.

"Veterinary Practice Act" means Title 59, Section 698.1 et seq. of the Oklahoma Statutes.

"Wildlife rehabilitation facility" means a non-profit organization that cares for and rehabilitates sick or injured wildlife.

775:10-8-3. Application for certification form; time for filing

(a) Any person who desires to be certified as an animal euthanasia technician must make written application on printed forms provided by the Board.

(b) An application for certification shall be sworn to and accompanied by fees as listed in Rule 775:10-3-12(a)(7). The application shall be filed with the Board not less than ~~ninety (90)~~ seven (7) calendar days prior to the date of the examination for certification.

(c) The applicant shall submit satisfactory proof that the applicant:

- (1) Is of good moral character;
- (2) Is at least 21 years of age;
- (3) Has received a high school diploma or its equivalent, or the applicant has submitted additional information and three (3) sworn letters of recommendation.
- (4) Is a citizen of the United States or is lawfully entitled to remain and work in the United States;
- (5) Has not been convicted of, or entered a plea of guilty or nolo contendere to, a felony or misdemeanor involving cruelty to animals, moral turpitude or relating to any controlled dangerous substance as defined by the Uniform Controlled Dangerous Substance Act, in this or any other jurisdiction;
- (6) Has successfully completed a course which complies with the requirements of the Board for the training of animal euthanasia technicians, as set forth in Rules 775:10-8-32 and 775:10-8-33; and

(7) Is an employee of a law enforcement agency, animal control agency, or animal shelter. An applicant who has satisfied all other requirements for certification, including passing the examination for certification, shall be considered as eligible for certification and a certificate shall be issued when verification of employment by a law enforcement agency, animal control agency, or animal shelter recognized and approved by the Board has been received by the Board. No certificate shall be issued until verification of employment by a law enforcement agency, animal control agency, or animal shelter recognized and approved by the Board has been received by the Board.

(d) Any person who shall apply for certification as an animal euthanasia technician in the State of Oklahoma shall undergo a national fingerprint-based criminal history search ~~performed in accordance with either Rule 775:10-8-3(d)(1) or 775:10-8-3(d)(2).~~

(1) The employing Law Enforcement Agency may submit the applicant's fingerprint cards to the Oklahoma State Bureau of Investigation (OSBI) and the FBI directly.

(A) When the reports of the criminal history search are received by the employing Law Enforcement Agency it shall submit a copy of the reports to the Board ~~accompanied by a signed and notarized letter/affidavit that the reports submitted are true and accurate copies of the original reports.~~

(2) The applicant shall may submit to the Board or its agent(s), as part of the application for certification, two (2) completed fingerprint cards ~~on FBI Form FD-258.~~ The fingerprint cards shall bear full sets of the applicant's fingerprints created by a law enforcement agency ~~of the jurisdiction of the applicant's residency.~~

~~(A) The Board shall forward the fingerprint cards, along with the applicable fee for a national fingerprint-based criminal history check, to the Oklahoma State Bureau of Investigation (OSBI).~~

~~(B) The OSBI shall retain one set of fingerprints in the Automated Fingerprint Identification System (AFIS), and submit the other set to the Federal Bureau of Investigation for a national fingerprint based criminal history search.~~

~~(C) The Board shall have the authority to collect the applicable fee for the national criminal history check from the applicant in addition to any other fee prescribed by statute or by the Board for certification.~~

(3) No application for certification shall be considered complete until the reports from the national fingerprint-based criminal history search have been received ~~obtained~~ by the Board.

~~(e) No application shall be considered until the application is complete.~~

~~(f) An application for certification may be thoroughly investigated. The Board or its agent(s) may inquire from the references or by such other means as the Board deems expedient as to the accuracy of the information submitted. If the replies from the references cited are not received within a reasonable time the Board may so notify the applicant and may request additional references. Information so obtained~~

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shall be filed with the application as a permanent record and shall remain the property of the Board.

(~~ef~~) The Board reserves the authority to require any applicant to provide additional information or evidence to support an application for certification. The Board may require an applicant to appear before the Board to provide the Board such additional information or evidence.

(~~hg~~) The Board or its agent(s) may deny certification of an applicant based on evidence of unsuitability of the applicant or failure of the applicant to satisfy any of the requirements for certification.

775:10-8-4. Employment requirements for certification

(a) Any person who submits an application to be certified as an animal euthanasia technician shall provide notarized, documented proof of employment by a law enforcement agency, animal control agency, or animal shelter recognized and approved by the Board before a certificate will be issued.

(b) ~~An A animal euthanasia technician CAET shall be required to maintain active employment by at least one law enforcement agency, animal control agency, or animal shelter recognized and approved by the Board for the purposes of holding a valid Animal Euthanasia Technician certificate.~~

(c) ~~An A animal euthanasia technician CAET employed by a law enforcement agency, animal control agency, or animal shelter recognized and approved by the Board may enter into a contract to provide animal euthanasia services to another law enforcement agency, animal control agency, or animal shelter recognized and approved by the Board providing:~~

~~(1) The Animal Euthanasia Technician obtains separate Certificates of Registration from the OBN and DEA for each location where controlled dangerous substances will be administered or stored;~~

~~(2) The contract for services contains a clause immediately terminating the contract if the Animal Euthanasia Technician either ceases to be an employee of a law enforcement agency, animal control agency, or animal shelter recognized and approved by the Board or the certificate of the Animal Euthanasia Technician CAET is suspended, revoked or denied renewal; and~~

~~(3) A copy of every contract to provide euthanasia services is submitted to the Board within five (5) business days of the execution (signing) of the contract by both parties to the contract.~~

775:10-8-5. Examination for certification

(a) The Board or its agent(s) shall examine every qualified applicant for certification as an Animal Euthanasia Technician to determine the applicant's qualifications.

(b) The examination shall consist of a written examination and a practical examination.

(c) The written examination shall be administered by the Board or its agent(s) and shall include questions covering the materials and topics included in, but not limited to, the:

(1) Veterinary Practice Act; and Rules, Oklahoma Bureau Narcotics and Drug Enforcement Administration Laws and Rules.

~~(2) Rules under Title 775, Chapter 10, Subchapter 8: Certification of Animal Euthanasia Technicians;~~

~~(3) Rules under Title 775, Chapter 15, Subchapter 3: Investigations and Disciplinary Actions; and~~

~~(4) Rules under Title 475 of the Oklahoma Administrative Code and under Sections 1300 et seq. of Chapter 21 of the Code of Federal Regulations governing registration of practitioners and the security and record keeping requirements for the purchase, possession, administration, transfer and disposal of controlled dangerous substances.~~

(5) Correct calculation of a dosage of a euthanasia drug not less than the minimum recommended by the manufacturer or approved by the Board.

(d) An applicant shall score no less than 70 percent on the written examination ~~before the applicant will be admitted to the practical examination.~~

(e) The practical examination shall be administered by the Board or its agent(s) and shall require the examinee to demonstrate competence in the following subjects:

(1) Administration of injectable agents by:

(A) Proper intravenous injection of a sterile solution into a vein of an animal in at least one of two attempts;

(B) Intraperitoneal injection by proper insertion of a needle into the injection site in at least one of two attempts; and

(C) Intracardiac injection by proper insertion of a needle into the heart of an anesthetized or unconscious animal in at least one of two attempts.

(2) Proper selection and handling of needles by:

(A) Selecting a needle of the appropriate gauge and length for the size of the animal and the route of administration; and

(B) Using universal precautions for handling and disposal of needles and syringes.

(3) Handling of animals by:

(A) Exercising care and regard for the humane treatment of animals;

(B) Exercising care and regard for human safety;

(C) Using appropriate restraining devices and techniques for the control of fractious or potentially dangerous animals;

(D) Communicating effectively with an animal handler;

(E) Using appropriate techniques and criteria to accurately determine the level of consciousness of an animal; and

(F) Using appropriate techniques and criteria to verify the death of an animal.

(f) A score of 100 percent shall be obtained by the applicant on the practical portion of the exam.

~~(g) An applicant must pass the practical examination within twelve (12) months of passing the written examination.~~

(h) ~~If an applicant fails to pass the practical examination within twelve (12) months of passing the written examination, the Board may require the applicant to:~~

- ~~(1) Provide documentation of additional training; and/or~~
- ~~(2) Retake and pass the written examination.~~

775:10-8-6. Issuance of a certificate; Renewal of certificate; Reinstatement of certificate; Fees of the Board

(a) The Board shall have the authority to issue an Animal Euthanasia Technician certificate after an applicant has completed all requirements for certification.

(b) Every Animal Euthanasia Technician who is the holder of a certificate authorizing animal euthanasia, shall, on or before the first day of July of each and every year, apply to the Board on forms furnished by the Board for a renewal certificate of registration entitling such technician to perform animal euthanasia techniques in this state during the next fiscal year. A renewal fee in an amount fixed by the Board shall accompany each such application.

(c) Failure to renew a certificate on or before the first day of July shall cause the certificate to be considered suspended for failure to renew and subject to the provisions of Rule 775:10-8-11.

(d) If, on or before the thirty-first day of July, the certificate holder pays the renewal fee plus any reactivation fee set by the Board, the President or Secretary-Treasurer of the Board may reactivate the certificate.

(e) If the certificate is not reactivated before the first day of August, the certificate shall be considered as lapsed, and the certificate may be reinstated only upon approval by the Board after proper re-application of the certificate holder.

~~(f) The Board shall have the authority to charge for the following:~~

- ~~(1) For processing the application of a person seeking certification as an Animal Euthanasia Technician;~~
- ~~(2) For a national criminal history background check;~~
- ~~(3) For the training of a person seeking certification as an Animal Euthanasia Technician;~~
- ~~(4) For the examination of a person seeking certification as an Animal Euthanasia Technician;~~
- ~~(5) For the original certificate and a yearly renewal; and~~
- ~~(6) For reactivation of a certificate.~~

~~(g) The Board shall not refund any fees once collected.~~

~~(h) The Board may issue a certificate to an Animal Euthanasia Technician only after payment of the appropriate fees.~~

~~(i) The Board or its agent(s) may require any individual who has received a certificate as an Animal Euthanasia Technician to retake all or part of the examination and/or attend all or part of the training course as necessary to verify the individual's qualifications to hold a certificate as part of the process for annual renewal or reactivation of a certificate or as the result of investigative findings and/or disciplinary action by the Board.~~

~~(j) Performing animal euthanasia by administering a controlled dangerous substance or any other drug approved for euthanasia by the Board or the Animal Industries Services Division of the State Department of Agriculture is unlawful~~

unless the individual administering the drug is a licensed veterinarian, an Animal Euthanasia Technician whose certificate is active and in good standing, or the individual is working under the direct supervision of a licensed veterinarian.

775:10-8-7. Continuing education hours required for renewal of certificate

(a) Before any certificate is renewed, the certificate holder shall certify on a form provided by the Board that ~~he/she has~~ they have obtained six (6) hours of continuing education approved by the Board which covers topics that relate to animal euthanasia, the care and custody of animals in preparation for adoption and/or shelter management. Acceptable hours of credit will be determined as follows:

- (1) One hour of credit for each hour of attendance at veterinary college and extension seminars, and veterinary technology schools.
- (2) One hour of credit for each hour of attendance at national, regional, state or local approved scientific meetings.
- (3) One hour of credit for each hour of study with audio-tutorial tapes or reading of scientific or non-scientific articles in journals or periodicals pertaining to animal euthanasia, the care and custody of animals in preparation for adoption and/or shelter management. A maximum of two hours credit may be gained by this means.
- (4) Two hours of continuing education per year must encompass review of state and federal controlled dangerous substance laws and applicable rules and regulations and/or review of the Oklahoma Veterinary Practice Act and applicable rules.

~~(b) Individuals who are certified as an Animal Euthanasia Technicians~~ CAET in the State of Oklahoma within one calendar year of completing a training course for Animal Euthanasia Technicians are exempt from reporting continuing education credits until submission of the second renewal application after initial certification.

(c) The Board or its agent(s) may waive all or part of the required continuing education hours and accept in lieu training or education considered comparable by the Board.

(d) Each certificate holder shall maintain verifiable documentary proof of attendance of reported continuing education credit in a readily retrievable file for random audit purposes. Documentary proof shall be maintained for a period of five years from the date of attendance.

(e) Only those courses, meetings or seminars previously approved and/or offered by the American Veterinary Medical Association (AVMA), the American Association of Veterinary State Boards (AAVSB), or any other state veterinary board or recognized state veterinary association, shall not require previous approval by the Board to qualify as continuing education hours to be counted towards the fulfillment of the six (6) required hours, so long as the material offered complies with the requirements of this section or comply with Rules 775:10-3-5(f)(h)(i).

~~(f) Regional veterinary associations, corporations, and any other organizations or individuals must submit course material to the Board for evaluation to qualify for continuing education~~

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hours being offered at regional or local meetings, and shall adhere to the following procedure:

- ~~(1) Submit a published notice of the meeting;~~
 - ~~(2) Submit a planned program as evidenced by a published agenda;~~
 - ~~(3) Submit a formal presentation on printed material (i.e. papers, brochures, videos with printed material describing the video contents, etc);~~
 - ~~(4) Submit a verification of attendance form after the conclusion of the meeting, which contains the attendee's printed name and signature taken prior to the initiation of the material presented and the attendee's printed name and signature after the conclusion of the material presented.~~
- ~~(g) The Vice President of the Board may evaluate and approve any Continuing Education (CE) credit requests received by the Board, or the Vice President of the Board may submit the request to the Board for consideration at the next regularly scheduled meeting of the Board.~~
- ~~(h) Regional veterinary associations, corporations, and any other organizations or individuals that submit Continuing Education credit requests which are deemed ineligible for Continuing Education credit may appeal the decision upon the presentation of new and additional material for consideration at the next regularly scheduled meeting of the Board.~~

775:10-8-10. Duties of Animal Euthanasia Technicians

An Animal Euthanasia Technician shall perform all euthanasia services in a professional manner and with due regard for the humane treatment of animals and for the safety of the public. The duties of an Animal Euthanasia Technician shall include, but are not limited to:

- (1) Maintaining active certification as an Animal Euthanasia Technician;
- (2) Maintaining current Certificates of Registration with the OBN and DEA for every location where controlled dangerous substances are administered or stored;
- (3) Promptly reporting any change of address or other contact information to the Board, the OBN and DEA;
- (4) Performing animal euthanasia in accordance with Rules 775:10-8-16 through 775:10-8-19;
- (5) Supervising and communicating effectively with an animal handler who is aiding during the euthanasia of an animal;
- (6) Verifying death of an animal before disposal of the body;
- (7) Maintaining the security of all controlled dangerous substances and other drugs used for the purposes of animal euthanasia;
- (8) Promptly and accurately recording the quantity of controlled dangerous substances administered to animals and any drug waste;
- (9) Reporting suspected or documented theft or diversion of controlled dangerous substances to the Board, DEA and OBN within three calendar days in accordance with Rule 775:10-8-15;
- (10) Promptly reporting a violation of the Oklahoma Veterinary Practice Act or implementing rules to the Board;

- (11) Promptly reporting a violation of the federal or state Uniform Controlled Dangerous Substances Acts or implementing rules or regulations to the OBN and/or DEA; and
- (12) Filing a written response to a formal complaint or inquiry from the Board within ~~twenty (20) ten (10) days~~ after service of the formal complaint or inquiry, as required by Rule 775:15-3-6.

775:10-8-11. Duties of an Animal Euthanasia Technician upon cessation of qualified employment

When an Animal Euthanasia Technician fails to renew a certificate on or before the first day of July of each and every year, or ceases to be employed by a law enforcement agency, animal control agency, or animal shelter that is recognized and approved by the Board, the animal euthanasia technician or the employing agency shall within 5 days:

- (1) ~~immediately, and within the same business day,~~ notify the Board by phone, ~~and~~ in writing by facsimile, or electronic mail, and
- ~~(2) within three business days:~~
 - ~~(A) physically surrender his/her certificate to the Board or its agent(s); and either~~
 - ~~(B) surrender all controlled dangerous substances to the OSBI for destruction, and~~
 - ~~(i) provide the Board or its agent(s) with a copy of the date/time stamped OSBI CF 2 Destruction Form;~~
 - ~~(ii) provide written documentation to the Board or its agent(s) that the OBN Certificate of Registration, the DEA Certificate of Registration and all unexecuted order forms for Schedule II drugs (DEA Form 222) for all registered locations have been voluntarily surrendered; and~~
 - ~~(iii) provide the Board or its agent(s) a copy of the previous two years of controlled substance administration records for all registered locations;~~
 - ~~or~~
 - ~~(C) obtain authorization from OBN and transfer all controlled dangerous substances to another registrant who is either a certified Animal Euthanasia Technician or a licensed veterinarian, and~~
 - ~~(i) provide the Board or its agent(s) copies of the written entries in the controlled substances log book substantiating such transfer;~~
 - ~~(ii) provide written documentation to the Board or its agent(s) that the OBN Certificate of Registration, the DEA Certificate of Registration and all unexecuted order forms for Schedule II drugs (DEA Form 222) for all registered locations have been voluntarily surrendered; and~~
 - ~~(iii) provide the Board or its agent(s) a copy of the previous two years of controlled substance administration records for all registered locations.~~
 - ~~(3) The Board shall be notified in writing within 5 days of cessation of employment to the OBNDD and DEA.~~

775:10-8-12. Registration of Animal Euthanasia Technicians to purchase and possess controlled dangerous substances

(a) An Animal Euthanasia Technician shall register as a mid-level practitioner with, and have received Certificates of Registration from the OBN and DEA, prior to the purchase, possession or administration of any drugs for the purposes of animal euthanasia, except that an Animal Euthanasia Technician working under the direct supervision of a licensed veterinarian may administer drugs for the purposes of animal euthanasia prior to receiving his/her Certificates of Registration from OBN and DEA.

(b) An Animal Euthanasia Technician shall obtain separate Certificates of Registration for every location where controlled dangerous substances are administered or stored.

(c) An Animal Euthanasia Technician shall submit a copy of each OBN and DEA Certificate of Registration for each registered location to the Board within five business days of receiving each initial Certificate of Registration and within five business days of the renewal of each Certificate of Registration.

775:10-8-14. Storage and security of controlled dangerous substances, certificates of registration and drug order forms

(a) All controlled dangerous substances shall be stored in accordance with the Uniformed Controlled Dangerous Substances Act and implementing state and federal rules and regulations at the level of security required for practitioners. The level of security required may vary depending on the registered location, the number of employees and other personnel who have access to the area where controlled substances are stored, the quantity of controlled substances kept on hand, and the prior history of theft or diversion. Specific questions regarding the adequacy of security measures shall be directed to the OBN and/or DEA.

(b) The law enforcement agency, animal control agency or animal shelter where animal euthanasia is performed shall provide for the storage and security of controlled dangerous substances, unless a contract exists between a law enforcement agency, animal control agency or an animal shelter and an Animal Euthanasia Technician, in which case the controlled dangerous substances may be stored at another location, so long as the Animal Euthanasia Technician has OBN and DEA Certificates of Registration for that location.

(c) Controlled dangerous substances shall be stored in a securely locked substantially constructed cabinet which is securely attached to the building in which it is housed, and which is accessible only to the Animal Euthanasia Technician or other individual who has current OBN/DEA Certificates of Registration for the schedules of drugs stored in the cabinet.

(d) If the controlled dangerous substances are stored in a safe or cabinet that can be opened by any person other than an Animal Euthanasia Technician or other OBN/DEA registrant, the controlled dangerous substances shall be stored within the cabinet or safe in a separate securely locked metal container which

cannot be removed from the cabinet or safe and is accessible only to the Animal Euthanasia Technician or other OBN/DEA registrant.

(e) Controlled dangerous substances transported from the registered location shall be stored in a securely locked metal box which is only accessible to the Animal Euthanasia Technician or other individual who has current OBN/DEA Certificates of Registration for the schedules of drugs stored in the box, and which is:

(1) Securely attached to the vehicle in which it is being transported; or

(2) Secured in a locked trunk of the vehicle which is separate from the passenger compartment; or

(3) Is under the direct control of the Animal Euthanasia Technician or other OBN/DEA registrant; and

(4) Copies of the Animal Euthanasia Technician's certificate, OBN and DEA Certificates of Registration, and the original drug administration record forms for each primary container of controlled substances stored in the box shall be retained inside the locked box.

(f) Controlled dangerous substances must be stored in an environment that meets the manufacturer's recommendations for proper storage.

(g) The Animal Euthanasia Technician's original OBN and DEA Certificates of Registration shall be maintained in a securely locked substantially constructed cabinet which is accessible only to the Animal Euthanasia Technician or another individual who has current OBN/DEA Certificates of Registration.

(h) Unexecuted order forms for Schedule II drugs (DEA Form 222) shall be secured in a securely locked substantially constructed cabinet which is accessible only to the Animal Euthanasia Technician or other individual who has current OBN/DEA Certificates of Registration for Schedule II drugs.

775:10-8-15. Maintenance of records and inventories of controlled dangerous substances

(a) An Animal Euthanasia Technician shall comply with all applicable State and Federal laws, rules and regulations relating to, but not limited to, registration, ordering and receiving, security, record keeping, inventory and disposal of controlled dangerous substances.

(b) An Animal Euthanasia Technician shall ensure that each primary commercial container of a controlled dangerous substance is labeled with a unique numeric or alphanumeric code assigned to each primary container by the Animal Euthanasia Technician and the date the drug was prepared or reconstituted, if applicable.

(c) An Animal Euthanasia Technician shall ensure that each primary non-commercial container of controlled dangerous substance is labeled with the name of the drug, the strength, a warning of the hazards, the name, address, and current telephone number of the Animal Euthanasia Technician, a unique numeric or alphanumeric code assigned to each primary container by the Animal Euthanasia Technician, and the date that the drug was prepared or reconstituted.

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~~(d) An Animal Euthanasia Technician shall maintain current accurate records of the purchase, administration, transfer and disposal of every primary commercial and non-commercial container of a controlled dangerous substance. Such records shall consist of:~~

- ~~(1) A master log book containing information about the purchase, receipt, transfer and/or disposal of every primary commercial container of a controlled dangerous substance;~~
- ~~(2) Drug administration records for every primary commercial and non-commercial container of a controlled dangerous substance;~~
- ~~(3) A weekly physical inventory of all controlled dangerous substances; and~~
- ~~(4) The OBN/DEA registrant's copies of all executed or void order forms for Schedule II drugs (Form DEA 222).~~

(b) A CAET shall keep inventory of all controlled dangerous substances and maintain a running count of the master log book.

~~(ec) The master log book shall be:~~

- ~~(1) Be in the form of a bound ledger or substantially constructed three-ring binder that is identified on the cover with the name of Animal Euthanasia Technician and the registered location (e.g., the name and address of the law enforcement or animal control agency or animal shelter);~~
- ~~(2) Contain the required information either in a format approved by the Board or on forms either provided or approved by the Board;~~
- ~~(3) Contain, at a minimum, the following information recorded in chronological order:
 - ~~(A) The date the controlled dangerous substance was received;~~
 - ~~(B) The invoice or purchase order number (if applicable);~~
 - ~~(C) The number of the DEA Form 222 used to order the controlled dangerous substances (if applicable);~~
 - ~~(D) The lot number(s) recorded on the primary commercial containers of the controlled dangerous substance by the manufacturer; and~~
 - ~~(E) A list of the unique numeric or alphanumeric codes assigned to and recorded on each individual primary commercial container of a controlled dangerous substance by the Animal Euthanasia Technician.~~
 - ~~(F) If a controlled dangerous substance is transferred from a primary commercial container to one or more non-commercial containers, the date(s) of such transfer and the unique numeric or alphanumeric codes assigned to the primary non-commercial container(s) into which the substance was transferred shall be recorded in addition to the other information required for each primary commercial container.~~~~

~~(4) Have the records for the purchase, receipt, transfer and disposal of Schedule II controlled dangerous substances in a section which is separate from the records for the purchase, receipt, transfer and disposal of controlled dangerous substances in Schedules III through V;~~

~~(5) Be maintained in a securely locked substantially constructed cabinet which is accessible only to the Animal Euthanasia Technician or another individual who has current OBN/DEA Certificates of Registration.~~

~~(fd) The drug administration records shall: be recorded on a form provided by the Board or approved by the Board.~~

- ~~(1) Be;~~
- ~~(2) Consist of a separate form for each primary commercial or non-commercial container of a controlled dangerous substance on which is recorded:
 - ~~(A) The generic name of the controlled substance;~~
 - ~~(B) The volume of the container;~~
 - ~~(C) The concentration of the controlled substance in milligrams per milliliter, capsule or tablet, as applicable;~~
 - ~~(D) The unique numeric or alphanumeric code assigned to the primary commercial or non-commercial container by the Animal Euthanasia Technician;~~
 - ~~(E) The species, weight and individual identification number (if applicable) of every animal to which the contents of the container were administered, the route of administration and the volume or amount of controlled dangerous substances administered; and~~
 - ~~(F) The remaining balance of the controlled dangerous substance in the container.~~~~

~~(3) Be maintained at the registered location in a readily retrievable file or substantially constructed three ring binder; and~~

~~(4) Drug administration records for Schedule II drugs shall be maintained separate from drug administration records for controlled substances in Schedules III through V. Separation may be by use of separate labeled file folders or by use of separate labeled sections within a three ring binder.~~

~~(g) The weekly physical inventory of controlled dangerous substances shall:~~

- ~~(1) Be recorded on a form provided by or approved by the Board;~~
- ~~(2) Be performed on the same day of every week. The inventory may be conducted at the beginning or end of the day so long as the time the inventory was performed is recorded on the inventory form;~~
- ~~(3) Shall be compared against the records in the master log book and the drug administration records and agreement or discrepancies between the physical inventory and those records duly noted;~~
- ~~(4) Be signed or initialed by the Animal Euthanasia Technician; and~~
- ~~(5) Be maintained in a readily retrievable file at the registered location where controlled dangerous substances are stored.~~

~~(h) The registrant's copy of all executed or void order forms for Schedule II substances (DEA Form 222) shall be maintained in a readily retrievable file or binder.~~

~~(i) An Animal Euthanasia Technician shall report suspected or documented theft and or diversion of controlled dangerous substances on a DEA Form 106 to the Board, DEA and OBN~~

~~within three calendar days of suspicion or discovery of theft or diversion.~~

~~(je) An Animal Euthanasia Technician having one or more contracts to provide animal euthanasia services to a law enforcement agency, animal control agency or animal shelter shall maintain the original copies of the records required by Rule 775:10-8-15(d) at the registered location where controlled substances were stored. If the location where controlled dangerous substances are administered is different than the registered location where controlled substances were stored, the Animal Euthanasia Technician shall provide a current duplicate copy of the records required by Rule 775:10-8-15(d) to the law enforcement agency, animal control agency or animal shelter where the controlled dangerous substances were administered. Duplicate copies of the records shall be clearly marked as copies.~~

~~(kf) The original copies of the records required by Rule 775:10-8-15(d) shall be maintained at the registered location for not less than two years.~~

~~(l) If an Animal Euthanasia Technician surrenders his/her OBN and DEA Certificates of Registration for a registered location, the original copies of the records required by Rule 775:10-8-15(d) shall be either:~~

~~(1) Retained at the registered location, if the registered location is a law enforcement agency, animal control agency or animal shelter where animal euthanasia services were performed; or~~

~~(2) Surrendered to the OBN if the registered location is the Animal Euthanasia Technician's place of residence or other location where animal euthanasia services were not performed under contract with a law enforcement agency, animal control agency or animal shelter.~~

775:10-8-16. Standards for euthanasia of animals in the custody of a law enforcement agency, animal control agency or animal shelter.

In accordance with Sections 501 et seq. of Title 4 of the Oklahoma Statutes, the euthanasia of animals held by or in the custody of a law enforcement agency, animal control agency or animal shelter shall comply with the standards set forth in this chapter.

(1) Euthanasia of animals shall be performed by one of the following methods:

(A) administration of denatured sodium pentobarbital; ~~or~~

(B) the use of a carbon monoxide chamber, using commercially compressed cylinder gas, provided that kittens and puppies under the age of sixteen (16) weeks shall not be euthanized with carbon monoxide but with injections of denatured sodium pentobarbital or other drugs not prohibited by statute approved for euthanasia by the Board, ~~or the Animal Industries Services Division of the State Department of Agriculture; or~~

~~(C) any other method approved by the Board or the Animal Industries Services Division of the State Department of Agriculture.~~

(2) The method of euthanasia shall be as painless as possible to the animal as determined by the best available medical and scientific knowledge and technology.

(3) The animal shall be kept as free from anxiety and fear as possible.

(4) Death shall be confirmed by the cessation of all vital signs.

~~(5) Denatured sodium pentobarbital and other drugs not prohibited by statute approved for euthanasia of animals by the Board or the Animal Industries Services Division of the State Department of Agriculture shall be administered only by a licensed veterinarian, a certified animal euthanasia technician, or a person trained for this purpose and under the direct supervision of a licensed veterinarian.~~

~~(6) All controlled dangerous substances and other drugs approved by the Board or the Animal Industries Services Division of the State Department of Agriculture for euthanasia of animals must be stored in an environment that meets the manufacturer's recommendations for proper storage.~~

~~(7) No controlled dangerous substances or other drugs approved by the Board or the Animal Industries Services Division of the State Department of Agriculture for euthanasia of animals shall be used to euthanize an animal after the expiration date printed on the primary commercial container by the manufacturer. All expired drugs shall be disposed of in accordance with state and federal laws and implementing rules and regulations.~~

775:10-8-17. Standards for injection of animals.

Any person performing animal euthanasia by injection of denatured sodium pentobarbital or other drug approved for animal euthanasia ~~by the Board or the Animal Industries Services Division of the State Department of Agriculture~~ shall comply with the following standards for the injection of an animal:

(1) Except as otherwise provided in 775:10-8-17(a)(2) and 775:10-8-17(a)(5), an animal shall be held or restrained after injection of a euthanasia drug until the animal is unconscious.

(2) If an animal should not be held or restrained because holding or other physical restraint would either increase the anxiety or fear of the animal or would place the person holding or restraining the animal in physical danger, it must be placed alone in an enclosure which is appropriate for the species and size of the animal and permits adequate visual observation of the animal, except that dogs or cats under the age of 16 weeks or other animals which have not been weaned may be placed together in an enclosure with their littermates and/or dam.

(3) An individual administering euthanasia drugs shall have available the assistance of an animal handler when administering an intravenous injection unless the animal is heavily sedated, anesthetized, or comatose.

(4) Intravenous injection must be used on all dogs and cats over the age of 16 weeks and any other animal, unless the physical condition, size or behavior of the animal

presents a danger to the individual performing the injection or the animal handler; the physical restraint required for intravenous injection would cause unnecessary fear or anxiety in the animal; or the small size of the animal would make location and injection into a vein extremely difficult or impossible.

(5) A euthanasia drug may be administered by intraperitoneal injection only when the physical condition, size or behavior of the animal presents a danger to the individual performing the injection or the animal handler; the physical restraint required for intravenous injection would cause unnecessary fear or anxiety in the animal; or the small size of the animal would make location and injection into a vein extremely difficult or impossible.

(A) After an intraperitoneal injection of a euthanasia drug, the animal shall be placed alone in an enclosure which is appropriate for the species and size of the animal and permits adequate visual observation of the animal, except that dogs or cats under the age of 16 weeks or other animals which have not been weaned may be placed together in an enclosure with their littermates and/or dam.

(B) An animal which has received a euthanasia drug by intraperitoneal injection shall be observed every 5 minutes after injection until death is verified.

(6) Intracardiac injection shall not be performed on any animal unless it is heavily sedated, anesthetized, or comatose.

(7) The gauge and length of the needle used shall be appropriate for the size and species of animal and the method of injection.

(8) A new, unused disposable needle of medical quality shall be used for the administration of denatured sodium pentobarbital or other drug approved by the Board for euthanasia to each separate animal. A needle that is barbed or that may otherwise cause unnecessary discomfort to the animal shall never be used. Each needle shall be disposed of in a commercial sharps container immediately after a single use.

(9) The same syringe may be used to inject more than one animal so long as:

(A) A separate syringe is used for each euthanasia agent and each syringe is clearly labeled with the name of the drug for which it is used;

(B) All disposable syringes must be discarded in a commercial sharps container after the conclusion of all euthanasia procedures for a single day.

(C) All non-disposable syringes shall be cleaned and disinfected after the conclusion of all euthanasia procedures for a single day.

(10) An animal may be euthanized under field conditions when an emergency situation requires euthanasia to eliminate animal pain and suffering or is required for the safety of the public.

775:10-8-21. Complaints against an Animal Euthanasia Technician

~~(a)~~ In accordance with Rule 775:15-3-1, any person may file a citizen complaint with the Board in regard to any person certified as an Animal Euthanasia or any person who is performing animal euthanasia and is otherwise under the Board's statutory jurisdiction.

~~(b)~~ ~~Citizen complaints may be written or oral. The Board or its agent(s) may require complainants to reduce oral complaints to writing if such would facilitate the review of the complaint.~~

~~(c)~~ ~~The Board or its agent(s) shall investigate all facially credible citizen complaints over which the Board would reasonably have jurisdiction.~~

~~(d)~~ ~~In addition, the Board or its agent(s) may refer complaints to other entities for action, such as the OSBI, OBN, DEA, or other law enforcement agency, or appropriate district attorney, when such other entity has jurisdiction.~~

775:10-8-24. ~~Law enforcement agencies, animal control agencies and animal shelters;~~ Recognition and approval by the Board

(a) A law enforcement agency or animal control agency which intends to employ an Animal Euthanasia Technician or enter into a contract for services with an Animal Euthanasia Technician shall first apply to the Board for recognition and approval on a form provided by the Board.

(b) An animal shelter which intends to employ an Animal Euthanasia Technician or enter into a contract for services with an Animal Euthanasia Technician shall first apply to the Board for recognition and approval on a form provided by the Board. As part of the application the animal shelter shall be required to provide documentation that it is:

(1) A tax exempt organization, as defined by Title 26, Section 501(c)(3) of the United States Code (Internal Revenue Service), and is organized and operated exclusively for scientific or educational purposes, for the prevention of cruelty to animals, or for the care and rehabilitation of sick or injured wildlife; and

(2) Has obtained all licenses and/or permits required for the possession of wildlife under the rules implementing Title 29 of the Oklahoma Statutes (Game and Fish) and regulations implementing Title 16 of the United States Code (Fish and Wildlife).

775:10-8-25. ~~Law enforcement agencies, animal control agencies, and animal shelters;~~ Notice of termination of employment of a certified Animal Euthanasia Technician

Any law enforcement agency, animal control agency or animal shelter, whether directly employing an animal euthanasia technician or engaged in a contract for services with an Animal Euthanasia Technician shall notify the Board within ~~two~~ five business days of the termination of the employment or contractual agreement with the Animal Euthanasia Technician.

775:10-8-26. Inspection of law enforcement agencies, animal control agencies, animal shelters and registered locations; Notification and correction of deficiencies

(a) Under Title 63, Section 2-101 et seq. (Uniform Controlled Dangerous Substances Act) and Title 59, Section 698.1 et seq. (Veterinary Practice Act) of the Oklahoma State Statutes and implementing rules, any peace officer of the State of Oklahoma, including but not limited to Investigators from the Board, upon stating his/her purpose and presenting his/her credentials to the certificate holder, registrant, owner, operator, or agent(s) in charge of the premises where animal euthanasia is performed, shall have the right to enter such premises and conduct inspections at reasonable times and in a reasonable manner.

(b) ~~During the inspection of any agency, shelter or registered location, the peace officer shall examine:~~

- ~~(1) The security, storage and record keeping for controlled dangerous substances;~~
- ~~(2) The area, equipment and supplies used for animal euthanasia;~~
- ~~(3) Sanitation of the area where animal euthanasia is performed; and~~
- ~~(4) Any other condition that is relevant to the proper euthanasia of animals.~~

(c) ~~If a deficiency is found, the peace officer shall report the deficiency to the Board for proper review and/or investigation.~~

(d) ~~If a deficiency is found in the security, storage and/or record keeping of controlled dangerous substances, the peace officer shall also report the deficiency to the OBN and DEA for proper review and/or investigation.~~

775:10-8-27. Inspection of law enforcement agencies, animal control agencies, animal shelters and registered locations after discovery of deficiency; Failure to correct deficiency

(a) If a deficiency is found during a Board inspection of a law enforcement agency, animal control agency, animal shelter or registered location of an Animal Euthanasia Technician, and a field citation is issued which contains an abatement order pursuant to Section 698.19A of the Veterinary Practice Act, a Board investigator shall conduct a second inspection after the time specified for the correction of the deficiency and at the expense of the Animal Euthanasia Technician or the law enforcement agency, animal control agency or animal shelter.

(b) If the deficiency has not been corrected within the time specified for the correction of the deficiency:

- (1) A report shall be forwarded to the Secretary-Treasurer or Executive Director of the Board recommending that:
 - (A) The Animal Euthanasia Technician's certificate be suspended or revoked pursuant to the provisions of Rule 775:15-1-1 et seq. and/or a penalty imposed under Rule 775: 30-1-1; and/or
 - (B) The Board approval of the law enforcement agency, animal control agency or animal shelter be suspended or revoked pursuant to the provisions of

Rule 775:15-1-1 et seq. and/or a penalty imposed under Rule 775: 30-1-1.

(2) If the deficiency is related to the security, storage and/or record keeping for controlled dangerous substances, a report of any action taken by the Board shall be forwarded to DEA and OBN.

775:10-8-28. Complaints against a law enforcement agency, animal control agency, or animal shelter recognized and approved by the Board

(a) In accordance with Rule 775:15-3-1, any person may file a citizen complaint with the Board in regard to any law enforcement agency, animal control agency, or animal shelter that is recognized and approved by the Board or is otherwise under the Board's statutory jurisdiction.

(b) Citizen complaints may be written or oral. The Board or its agent(s) may require complainants to reduce oral complaints to writing if such would facilitate the review of the complaint.

(c) The Board or its agent(s) shall investigate all facially credible citizen complaints over which the Board would reasonably have jurisdiction.

(d) In addition, the Board or its agent(s) may refer complaints to other entities for action, such as the OSBI, OBN, DEA, or other law enforcement agency agencies, the State Department of Agriculture, or the Attorney General, when such other entity has jurisdiction.

775:10-8-29. Denial, suspension or revocation of Board recognition and approval of a law enforcement agency, animal control agency, or animal shelter

(a) The Board may deny, suspend or revoke the recognition and approval of a law enforcement agency, animal control agency, or animal shelter and/or impose a penalty upon an agency or shelter for:

- (1) Violation of any part of the Oklahoma Veterinary Practice Act or the Oklahoma Veterinary Administrative Rules;
- (2) Violation of Title 4, Section 501 et seq. of the Oklahoma Statutes;
- (3) Fraud, misrepresentation or deception in obtaining recognition and approval by the Board, or failure to provide accurate information upon request by the Board during an investigation or disciplinary hearing;
- (4) Violation of any state or federal laws and/or implementing rules or regulations relating to the purchase, storage or administration of controlled dangerous substances;
- (5) Having a working association with any person, agency or organization practicing veterinary medicine or performing animal euthanasia unlawfully;
- (6) Incompetence or negligence in performing animal euthanasia; or
- (7) Cruelty to animals.

(b) The President or Secretary-Treasurer of the Board may issue a confidential letter of concern to a certificate holder when, although evidence does not warrant formal proceedings,

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there has been noted indications of possible misconduct by the certificate holder that could lead to serious consequences and formal action.

(c) In the event it comes to the attention of the Board that a violation of the rules may have occurred, even though a formal complaint or charge may not have been filed, the Board may conduct an investigation of such possible violation, and may, upon its own motion, institute a formal complaint.

775:10-8-30. Emergency temporary suspension of Board recognition and approval of a law enforcement agency, animal control agency, or animal shelter

In accordance with Rule 775:15-3-4, the Secretary-Treasurer of the Board, or his/her designee, upon concurrence of the President or his/her designee, based upon clear and convincing evidence that an emergency exists for which the immediate suspension of the recognition and approval of the law enforcement agency, animal control agency, or animal shelter is imperative to protect the public or animal health, safety and welfare, may conduct a hearing to temporarily suspend the recognition and approval of the law enforcement agency, animal control agency, or animal shelter upon a showing of clear and convincing evidence of violation of the Veterinary Practice Act and implementing rules or Title 4, Section 501 et seq of the Oklahoma Statutes, provided any such action temporarily suspending recognition and approval is taken simultaneously with proceedings for setting a formal hearing pursuant to Rule 775:15-1-1 et seq. before the Board en banc to be held within thirty (30) days after emergency temporary suspension.

775:10-8-32. Required curriculum of training courses for Animal Euthanasia Technicians [REVOKED]

(a) The committee on Animal Euthanasia Technicians shall develop the curriculum for a training course for Animal Euthanasia Technicians acceptable to and approved by the Board or its agent(s).

(b) The course shall include, but not be limited to, the following topics of instruction:

- (1) The theory of animal euthanasia;
- (2) The Veterinary Practice Act and implementing rules;
- (3) Animal behavior, humane treatment and animal cruelty issues;
- (4) The Report of the AVMA Panel on Euthanasia and drugs approved for animal euthanasia by the Board;
- (5) Pharmacology of euthanasia drugs;
- (6) Calculation of drug dosages;
- (7) Anatomy of animals, with emphasis on injection sites;
- (8) Handling and restraint of animals;
- (9) Effective communication with an animal handler and training of handlers in appropriate handling and restraint techniques;
- (10) Techniques of injection and oral administration, including:

- (A) Intravenous injection of a dog and cat;
- (B) Intraperitoneal injection of a dog and cat;
- (C) Intracardiac injection of a dog and cat;
- (D) Preparation of euthanasia drugs for oral administration, including safety precautions;
- (11) Techniques for determining the level of consciousness of an animal;
- (12) Euthanasia of an animal;
- (13) Verification of death;
- (14) Universal precautions for handling and disposal of sharps and biohazards under Title 21, Section 1910.1030 of the Code of Federal Regulations;
- (15) OSHA and Department of Environmental Quality biohazard waste disposal requirements;
- (16) State and federal Uniform Controlled Dangerous Substance Acts and implementing rules and regulations, with emphasis on security and record keeping requirements for controlled dangerous substances;
- (17) Demonstration of proper record keeping for controlled dangerous substances;
- (18) Demonstration of methods for handling difficult situations; and
- (19) Grief and stress management; and
- (20) Handling of rabies suspects and other zoonotic diseases.

775:10-8-33. Approval of training courses for Animal Euthanasia Technicians offered by others [REVOKED]

The Board may approve a training course for Animal Euthanasia Technicians offered by another organization or individual. Such approval shall require submission of:

- (1) The course schedule;
- (2) A copy of all written materials, which are provided to the trainees;
- (3) A copy of all materials used during the training course, including papers, brochures, and videos with printed material describing the video contents;
- (4) The qualifications of all individuals who will be providing the training; and
- (5) The method by which the individual or organization will verify the completion of the training course by the trainee. Such verification shall be in the form of a certificate, which is issued to the trainee after the completion of the training and contains the following information:
 - (A) The name of the organization or individual providing the training;
 - (B) The name of the trainee;
 - (C) The title of the training course;
 - (D) The dates during which training occurred; and
 - (E) The signature of at least one individual who is responsible for the training program and who has knowledge of the trainee's attendance during the training program.

775:10-8-34. Committee on Animal Euthanasia Technicians; Creation; Membership; Duties [REVOKED]

(a) Pursuant to Section 698.5(C) of the Veterinary Practice Act, the Board may establish standing or ad hoc committees to facilitate the Board's work effectively, fulfill its duties and exercise its powers.

(b) Respective to the duties of the Board under Title 4, Title 59 and Title 63 of the Oklahoma Statutes for the certification of Animal Euthanasia Technicians, for the recognition and approval of law enforcement agencies, animal control agencies and animal shelters which employ or work in conjunction with Animal Euthanasia Technicians, and for the approval of controlled dangerous substances and other drugs to be used for animal euthanasia, the Committee on Animal Euthanasia Technicians is hereby created and shall consist of, but not be limited to:

- (1) The current Secretary-Treasurer of the Board, who shall chair the committee;
(2) The Executive Director of the Board;
(3) At least one licensed veterinarian from a State College or University offering an Associates Degree in Applied Veterinary Technology; and
(4) Any other licensed or certified professionals, which the Board President deems necessary.

(c) The committee shall:

- (1) Make recommendations to the Board regarding:
(A) Rules and changes to the rules for the certification of Animal Euthanasia Technicians, including but not limited to, the procedure for application, minimum requirements for initial certification, requirements for renewal of certification, standards of conduct and disciplinary action;
(B) Rules and changes to the rules for recognition and approval of law enforcement agencies, animal control agencies and animal shelters employing or working in conjunction with Animal Euthanasia Technicians including, but not limited to, minimum premise standards, inspections and disciplinary action;
(C) The methods of animal euthanasia, which should be approved by the Board, including drugs, dosages and routes of administration. The proposed methods should conform with the most recent Report of the AVMA Panel on Euthanasia and be as painless as possible to the animal as determined by the best available medical and scientific knowledge and technology;
(2) Develop a course for training individuals seeking certification as Animal Euthanasia training course.
(3) Offer the course to persons seeking training at least one time each year if a course, which meets the training requirements for certification and has been approved by the Board is not offered at least once each year by other organizations or individuals;

(4) Develop a written examination for the certification of Animal Euthanasia Technicians which can be administered to qualified applicants by the Board or its agents; and

(5) Develop a practical examination for the certification of Animal Euthanasia Technicians, which can be administered to qualified applicants by the Board or its agents.

[OAR Docket #10-464; filed 3-31-10]

TITLE 775. BOARD OF VETERINARY MEDICAL EXAMINERS CHAPTER 30. FIELD CITATION PENALTIES

[OAR Docket #10-465]

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PERMANENT final adoption

RULES:

775:30-1-1. Classifications and administrative penalties [AMENDED]

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N/A

ANALYSIS:

The proposed revisions to Chapter 30 changes a Class "A" violation not to exceed \$2,500.00 for a first violation.

CONTACT PERSON:

Cathy Kirkpatrick, Executive Director, 201 N.E 38th Terr. Suite 1, Oklahoma City, OK 73105, 405-524-9006

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 JULY 1, 2010:

Permanent Final Adoptions

775:30-1-1. Classifications and administrative penalties

(a) Each field citation issued pursuant to The Oklahoma Veterinary Practice Act and/or ~~rules~~ Rules of the Board shall be classified according to the nature of the violation as set out below. The field citation shall indicate the classification on its face.

(1) a Class "A" violation shall be a violation which the ~~executive~~ Executive ~~director~~ Director of the Board has determined meets the following criteria:

(A) it is the first violation by a person who while engaged in and/or aiding and abetting in the practice of veterinary medicine has violated the Oklahoma Veterinary Practice Act or the rules of the Board; and

(B) the probable cause committee does not recommend the filing of a formal Complaint and Citation to be adjudicated by the Board en banc.

(2) a Class "B" violation shall be a violation which the ~~executive~~ Executive ~~director~~ Director has determined meets the following criteria:

(A) it is the second or subsequent violation by a person who while engaged in and/or aiding and abetting in the practice of veterinary medicine has violated the Oklahoma Veterinary Practice Act or the rules of the Board; and

(B) the violation was committed by a person who has had one or more previous field citations preceding the instant violation, without regard to whether the previous Citation(s) has become final; and

(C) the probable cause committee does not recommend the filing of a formal Complaint and Citation to be adjudicated by the Board en banc.

(b) In recommending an administrative penalty or Board hearing, the following criteria shall be considered by the probable cause committee:

- (1) The good or bad faith exhibited by the cited person;
- (2) The nature and severity of the violation;
- (3) Evidence that the violation was willful;
- (4) Any history of violations of the same or similar nature;
- (5) The extent to which the cited person has cooperated with the Board's investigation;
- (6) The extent to which the cited person has mitigated or attempted to mitigate any damage or injury caused by the violation; and
- (7) Such other matters as justice may require.

(c) The specific administrative penalties shall be as follows:

- (1) a Class "A" violation shall be subject to an administrative penalty not to exceed ~~\$500.00~~ \$2,500.00;
- (2) a Class "B" violation shall be subject to an administrative penalty not to exceed \$5,000.00;
- (3) The administrative penalties required by this paragraph shall not be due and payable unless and until the previous action(s) has been adjudicated with a finding or penalty against the cited person;
- (4) In the event that a predicate field citation(s) is adjudicated in favor of the cited person, thereby leaving no recidivist basis, any pending Class "B" field citation(s) shall revert to a Class "A" status.

[OAR Docket #10-465; filed 3-31-10]

Executive Orders

As required by 75 O.S., Sections 255 and 256, Executive Orders issued by the Governor of Oklahoma are published in both the *Oklahoma Register* and the *Oklahoma Administrative Code*. Executive Orders are codified in Title 1 of the *Oklahoma Administrative Code*.

Pursuant to 75 O.S., Section 256(B)(3), "Executive Orders of previous gubernatorial administrations shall terminate ninety (90) calendar days following the inauguration of the next Governor unless otherwise terminated or continued during that time by Executive Order."

TITLE 1. EXECUTIVE ORDERS

1:2010-14.

EXECUTIVE ORDER 2010-14

I, Brad Henry, Governor of the State of Oklahoma, pursuant to the authority vested in me by Sections 1 and 2 of Article VI of the Oklahoma Constitution, hereby direct and order as follows:

Sections 1400U-1 and 1400U-2 of the Internal Revenue Code of 1986, as amended (the "Code"), as added by Section 1401 of Title 1 of Division B of the American Recovery and Reinvestment Act of 2009 ("ARRA"), authorize state and local governments to issue bonds ("Recovery Zone Economic Development Bonds") to finance expenditures for purposes of promoting economic activity ("Qualified Economic Development Purposes") within or attributable to recovery zones ("Recovery Zones") designated by the issuer of such Recovery Zone Economic Development Bonds.

Section 1400U-1 through 1400U-3 of the Code further authorize state and local governments to issue bonds ("Recovery Zone Facility Bonds" and, together with Recovery Zone Economic Development Bonds, "Recovery Zone Bonds") to finance property ("Recovery Zone Facilities") used in or attributable to the active conduct of a trade or business in a Recovery Zone.

Recovery Zone Bonds are a significant resource to the State to stimulate economic activity, increase employment opportunities, and mitigate the harmful effects of the national recession in areas with significant poverty, unemployment, rate of home foreclosures, or general distress among other criteria set forth in Section 1400U-1(b).

Section 1400U-1 of the Code imposes a national bond volume limitation ("Recovery Zone Volume Cap") on the issuance of Recovery Zone Bonds which is allocated among the states and among counties and large municipalities within the states based on relative declines in employment in 2008.

Oklahoma counties (each a "County") and municipalities with a population in excess of 100,000 (each a "Large Municipality") have received allocations of Recovery Zone Volume Cap for Recovery Zone Economic Development Bonds in the aggregate amount of \$90,000,000 and Recovery Zone Volume Cap for Recovery Zone Facility Bonds in the aggregate amount of \$135,000,000.

The Recovery Zone Volume Cap for Recovery Zone Economic Development Bonds and for Recovery Zone Facility Bonds has been allocated to the Counties and Large Municipalities in the State in the amounts set forth in Exhibit A.

Furthermore, Sections 1400U-2 and 1400U-3 of the Code provides that all Recovery Zone Bonds must be issued prior to January 1, 2011, and, by virtue of such requirement, it is imperative that the Recovery Zones in the State be designated, and Qualified Economic Development Purposes and Recovery Zone Facilities be identified, as soon as possible in order to assure that the resources provided by Recovery Zone Bonds are utilized in the State prior to that date.

Section 1400U-1(b) of the Code provides, in part, that a Recovery Zone can be any area having significant poverty, unemployment, rate of home foreclosures or general distress, among other criteria.

Section 1400U-1(a) (3) (A) of the Code and Notice 2009-50 issued by the Internal Revenue Service on June 12, 2009 (the "Notice") provide that any County or Large Municipality may waive any portion of its Recovery Zone Volume Cap to the State and upon such waiver the State is authorized to reallocate the waived Recovery Zone Volume Cap in any reasonable manner as it shall determine in good faith in its discretion.

I. Active Allocatees

- a. On July 10, 2009, on behalf of the Treasurer's office, the Oklahoma Department of Commerce (the "Department") sent to each County and Large Municipality that received allocations of Recovery Zone Volume Cap for Recovery Zone Economic Development Bonds and Recovery Zone Volume Cap for Recovery Zone Facility Bonds a letter enclosing Exhibit A and advising each County and Large Municipality to notify the Department of any planned use of the Recovery Zone Economic Development Bonds and Recovery Zone Facility Bonds by March 1, 2010.
- b. The City of Tulsa, Canadian County and Jackson County (the "Active Allocatees") were the only Counties and Large Municipality to make written responses.
- c. Any other County or Large Municipality listed on Exhibit A except for the Active Allocatees are deemed to have waived its allocation (the "Inactive Allocatees").

Executive Orders

d. The Active Allocatees have confirmed that each has an issuer that has been authorized by general and special laws heretofore enacted to issue bonds to finance projects and purposes which may constitute Qualified Economic Development Purposes.

II. Waiver and Reallocation

a. The Recovery Zone Volume Cap allocated to the In-Active Allocatees is hereby deemed waived to the State in accordance with Section 1400U-1(b) of the Code and the Notice.

b. All Recovery Zone Volume Cap that is deemed waived to the State pursuant to paragraph II(a) of this Order is hereby assigned to the Treasurer of the State of Oklahoma (the "Treasurer"). The Treasurer, may reallocate all or any portion of such Recovery Zone Volume Cap to such Qualified Economic Development Purposes or to such Recovery Zone Facilities, as applicable, as the Treasurer shall determine to be in the best interests of the State; provided however that all reallocations of Recovery Zone Volume Cap shall be consistent with and pursuant to Sections 1400U-1 through 1400U-3 of the Code, the Notice and this Executive Order.

c. Each reallocation of Recovery Zone Volume Cap made by the Treasurer shall be in writing, shall be made for specific Qualified Economic Development Purposes or Recovery Zone Facilities, as applicable, and shall specify the date on or before which the Recovery Zone Bonds to which such reallocated Recovery Zone Volume Cap pertains shall be issued in order for the allocation to be effective. Allocations may be made subject to those conditions that the Treasurer deems appropriate and consistent with this Executive Order.

d. The Treasurer is authorized to make all representations, file all documents and take all other actions as

may be required for compliance with Sections 1400U-1 through 1400U-3 of the Code and to implement this Executive Order.

e. The Treasurer shall make reasonably available to the public information as to the amount of the Recovery Zone Volume Cap allocated to the State and to any County or Large Municipality that has not yet been reallocated to Qualified Economic Development Purposes or Recovery Zone Facilities, as applicable, and the expiration dates for all reallocations by the Treasurer, and shall confirm, upon request, an allocation of the Recovery Zone Volume Cap to a particular Qualified Economic Development Purposes or Recovery Zone Facilities, as applicable, and the duration thereof.

This Executive Order shall be distributed to all members of the ARRA Coordinating Council, all members of the Governor's Executive Cabinet, and the chief executives of all appropriate and affected state agencies, who shall cause the provisions of this order to be implemented by all appropriate officials and agencies of state government.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City this 2nd day of April, 2010.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Brad Henry

ATTEST:
M. Susan Savage
Secretary of State



Area	Recovery Zone	
	Economic Development Residual	Recovery Zone Facility Bond
Oklahoma	90,000,000	135,000,000
Norman city, OK	1,247,000	1,871,000
Oklahoma City city, OK	0	0
Tulsa city, OK	50,425,000	75,639,000
Adair County, OK	0	0
Alfalfa County, OK	0	0
Atoka County, OK	21,000	31,000
Beaver County, OK	0	0
Beckham County, OK	0	0
Blaine County, OK	56,000	84,000
Bryan County, OK	2,627,000	3,941,000
Caddo County, OK	0	0
Canadian County, OK	Residual 6,659,000	9,988,000
Carter County, OK	0	0
Cherokee County, OK	3,906,000	5,859,000
Choctaw County, OK	0	0
Cimarron County, OK	0	0
Cleveland County, OK	Residual 0	0
Coal County, OK	0	0
Comanche County, OK	0	0
Cotton County, OK	206,000	308,000
Craig County, OK	0	0
Creek County, OK	1,895,000	2,843,000
Custer County, OK	0	0
Delaware County, OK	0	0
Dewey County, OK	0	0
Ellis County, OK	0	0
Garfield County, OK	0	0
Garvin County, OK	0	0
Grady County, OK	129,000	193,000
Grant County, OK	0	0
Greer County, OK	0	0
Harmon County, OK	0	0
Harper County, OK	0	0
Haskell County, OK	0	0
Hughes County, OK	0	0
Jackson County, OK	1,077,000	1,615,000
Jefferson County, OK	0	0
Johnston County, OK	0	0
Kay County, OK	0	0
Kingfisher County, OK	0	0
Kiowa County, OK	0	0
Latimer County, OK	0	0
Le Flore County, OK	2,122,000	3,183,000
Lincoln County, OK	80,000	120,000
Logan County, OK	98,000	146,000
Love County, OK	0	0
McClain County, OK	84,000	125,000
McCurtain County, OK	0	0
McIntosh County, OK	213,000	319,000
Major County, OK	0	0

Department of the Treasury
Internal Revenue Service

Executive Orders

Area	Recovery Zone		
	Residual	Economic Development Bond	Recovery Zone Facility Bond
Marshall County, OK		0	0
Mayes County, OK		467,000	700,000
Murray County, OK		0	0
Muskogee County, OK		0	0
Noble County, OK		1,132,000	1,699,000
Nowata County, OK		0	0
Okfuskee County, OK		258,000	387,000
Oklahoma County, OK	Residual	0	0
Okmulgee County, OK		972,000	1,458,000
Osage County, OK	Residual	1,052,000	1,578,000
Ottawa County, OK		0	0
Pawnee County, OK		449,000	674,000
Payne County, OK		8,035,000	12,052,000
Pittsburg County, OK		0	0
Pontotoc County, OK		526,000	789,000
Pottawatomie County, OK	Residual	0	0
Pushmataha County, OK		0	0
Roger Mills County, OK		0	0
Rogers County, OK		2,456,000	3,685,000
Seminole County, OK		0	0
Sequoyah County, OK		1,787,000	2,681,000
Stephens County, OK		0	0
Texas County, OK		14,000	21,000
Tillman County, OK		0	0
Tulsa County, OK	Residual	0	0
Wagoner County, OK		2,007,000	3,011,000
Washington County, OK		0	0
Washita County, OK		0	0
Woods County, OK		0	0
Woodward County, OK		0	0

Department of the Treasury
Internal Revenue Service

[OAR Docket #10-524; filed 4-5-10]

1:2010-15.

EXECUTIVE ORDER 2010-15

I, Brad Henry, Governor of the State of Oklahoma, hereby direct the appropriate steps be taken to fly all American and Oklahoma flags on State property at half-staff from 8:00 a.m. until 5:00 p.m. on Monday, April 5, 2010, to honor Robert Milacek, an Oklahoma resident, who died on Wednesday, March 31, 2010, at age 68.

Senator Milacek served in the Oklahoma State Senate from 1997 to 2004. Prior to that, Senator Milacek served in the Oklahoma State House of Representatives from 1976 to 1982. In addition to his public service, Senator Milacek taught and coached basketball for more than 20 years. Senator Milacek was a dedicated public servant and a faithful representative to his constituents. Throughout his life, Senator Milacek made great contributions to the State of Oklahoma.

This executive order shall be forwarded to the Director of Central Services who shall cause the provisions of this order to be implemented by all appropriate agencies of state government.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 2nd day of April, 2010.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Brad Henry

ATTEST:

Michelle Waddell
Acting Assistant Secretary of State

[OAR Docket #10-525; filed 4-5-10]

1:2010-16.

EXECUTIVE ORDER 2010-16

I, Brad Henry, Governor of the State of Oklahoma, hereby direct the appropriate steps be taken to fly all American and Oklahoma flags on State property at half-staff from 8:00 a.m.

until 5:00 p.m. on Saturday, April 10, 2010, to honor Wilma Pearl Mankiller, an Oklahoma resident, who died on Tuesday, April 6, 2010, at age 64.

In 1985, Wilma Mankiller became the Principal Chief of the Cherokee Nation, the first woman to hold such a position in any Indian tribe. During her decade of service as Chief, Mankiller met with Presidents, fostered strong relationships between the Cherokee Nation, the State of Oklahoma and the federal government, facilitated the establishment of the Office of Indian Justice within the United State Department of Justice, and led the Cherokee Nation in a time of growth and prosperity.

In 1998, President Bill Clinton awarded Chief Mankiller the Presidential Medal of Freedom, the nation's highest civilian honor, in recognition of her work on behalf of the Cherokee Nation, women, and Native Americans everywhere. Throughout her life, Chief Mankiller championed women's and Native American issues and served others through numerous philanthropic organizations.

Wilma Pearl Mankiller dedicated her life to public service and blazed a trail for others to follow. Her dedication to serving others, her passion for justice and her perseverance in the face of adversity inspired others in her lifetime, and her story and her achievements will be felt within the Cherokee Nation, the State of Oklahoma and around the world for many generations to come.

This executive order shall be forwarded to the Director of Central Services who shall cause the provisions of this order to be implemented by all appropriate agencies of state government.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 9th day of April, 2010.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Brad Henry

ATTEST:

M. Susan Savage
Secretary of State

[OAR Docket #10-626; filed 4-13-10]

