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Emergency Adoptions

"If an agency finds that a rule is necessary as an emergency measure, the rule may be promulgated" if the Governor approves the rules after determining "that the rule is necessary as an emergency measure to do any of the following:

- a. protect public health, safety or welfare,
- b. comply with deadlines in amendments to an agency's governing law or federal programs,
- c. avoid violation of federal law or regulation or other state law,
- d. avoid imminent reduction to the agency's budget, or
- e. avoid serious prejudice to the public interest." [75 O.S., Section 253(A)]

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next regular legislative session after its promulgation, or on an earlier date specified by the agency, if not already superseded by a permanent rule or terminated through legislative action as described in 75 O.S., Section 253(H)(2).

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

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

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

[OAR Docket #14-705]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 7. Soonercare
Part 3. Enrollment Criteria
317:25-7-13 [AMENDED]
Part 5. Enrollment Process
317:25-7-28 [AMENDED]
(Reference APA WF # 14-09)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 1115 Demonstration Project No. 11-W00048/6

ADOPTION:

June 26, 2014

APPROVED BY GOVERNOR:

July 1, 2014

EFFECTIVE:

Immediately upon governor's approval or July 1, 2014, whichever is later.

EXPIRATION:

Effective through September 14, 2015, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to SoonerCare Choice eligibility guidelines. These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program. Revisions are aligned with Special Terms and Conditions of the 1115 Demonstration Waiver. These emergency rule revisions will ensure OHCA policy is in compliance with waiver guidelines.

ANALYSIS:

SoonerCare Choice rules regarding enrollment ineligibility are amended to include making individuals with other forms of creditable health insurance coverage ineligible for SoonerCare Choice. Additionally, members who are currently enrolled in SoonerCare Choice who have or gain other forms of creditable insurance will be disenrolled from SoonerCare Choice. These changes are needed in order to reduce the overall costs of the Medicaid Program.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR JULY 1, 2014, WHICHEVER IS LATER AS SET FORTH IN 75 O.S., SECTION 253(F):

SUBCHAPTER 7. SOONERCARE

PART 3. ENROLLMENT CRITERIA

317:25-7-13. Enrollment ineligibility

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

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

Emergency Adoptions

(10) Individuals who have other primary medical insurance.

PART 5. ENROLLMENT PROCESS

317:25-7-28. Disenrolling a member from SoonerCare

- (a) The OHCA may disenroll a member from SoonerCare if:
- (1) the member is no longer eligible for SoonerCare services;
 - (2) the member has been incarcerated;
 - (3) the member dies;
 - (4) disenrollment is determined to be necessary by the OHCA;
 - (5) the status of the member changes, rendering him/her ineligible for SoonerCare;
 - (6) the member is already enrolled in the SoonerCare Program, when they are taken or found to be in custody as reported by the Oklahoma Department of Human Services;
 - (7) the member is authorized to receive services in a nursing facility, in an ~~intermediate care facility for the mentally retarded (ICF-MR)~~ Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or through a Home and Community Based Waiver; ~~or~~
 - (8) the member becomes dually-eligible for SoonerCare and Medicare; ~~or~~
 - (9) the member becomes covered under other primary medical insurance.
- (b) The OHCA may disenroll the member at any time if the member is disenrolled for good cause, as it is defined in OAC 317:25-7-27. The OHCA will inform the PCP of any disenrollments from his or her member roster.
- (c) OHCA may disenroll a member upon the PCP's request as described in (1) through (5) of this subsection.
- (1) The PCP may file a written request asking OHCA to take action including, but not limited to, disenrolling a member when the member:
 - (A) is physically or verbally abusive to office staff, providers and/or other patients;
 - (B) is habitually non-compliant with the documented medical directions of the PCP; or
 - (C) regularly fails to arrive for scheduled appointments without cancelling and the PCP has made all reasonable efforts to accommodate the member.
 - (2) The request from the PCP for disenrollment of a member must include one of more of the following:
 - (A) documentation of the difficulty encountered with the member including the nature, extent and frequency of abusive or harmful behavior, violence, and/or inability to treat or engage the member;
 - (B) identification and documentation of unique religious or cultural issues that may be effecting the PCP's ability to provide treatment effectively to the member; or
 - (C) documentation of special assistance or intervention offered.

(3) The PCP may not request disenrollment because of a change in the member's health status, the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs except when the member's enrollment with the PCP seriously impairs his/her ability to furnish services to this member or other members.

(4) The PCP must document efforts taken to inform the member orally or in writing of any actions that have interfered with the effective provision of covered services, as well as efforts to explain what actions or language of the member are acceptable and unacceptable and the consequences of unacceptable behavior, including disenrollment from the PCP.

(5) The OHCA will give written notice of the disenrollment request to the member.

[OAR Docket #14-705; filed 7-8-14]

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

[OAR Docket #14-701]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-5. [AMENDED]
(Reference APA WF # 14-05)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 447.43

ADOPTION:

June 26, 2014

APPROVED BY GOVERNOR:

July 1, 2014

EFFECTIVE:

Immediately upon governor's approval or July 1, 2014, whichever is later.

EXPIRATION:

Effective through September 14, 2015, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's general scope and administration guidelines. These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

ANALYSIS:

Agency's cost-sharing rules are revised to permit an increase of copays to the federal maximum.

CONTACT PERSON:

Tywanda Cox at (405)522-7153

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR JULY 1, 2014, WHICHEVER IS LATER AS SET FORTH IN 75 O.S., SECTION 253(F):

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-5. Assignment and Cost Sharing

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

- (1) "Fee-for-service contract" means the provider agreement specified in OAC 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority and medical providers which provides for a fee with a specified service involved.
(2) "Within the scope of services" means the set of covered services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.
(3) "Outside of the scope of the services" means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.

(b) Assignment in fee-for-service. The OHCA's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or co-payment required by the State Plan to be paid by the member and make no additional charges to the member or others.

- (1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.
(2) Once an assigned claim has been filed, the member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Provider Services.
(3) When potential assignment violations are detected, the OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the

assignment agreement, the OHCA is required to suspend further payment to the provider.

(c) Assignment in SoonerCare. Any provider who holds a fee for service contract and also executes a contract with a provider in the SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.

- (1) If the service provided to the member is outside of the scope of the services outlined in the SoonerCare Contract, then the provider may bill or seek collection from the member.
(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) of this subsection, the Oklahoma Health Care Authority shall be the final authority for this decision.
(3) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.

(d) Cost Sharing-Copayment. Section 1902(a)(14) of the Social Security Act permits states to require certain members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the fee for service program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges and it does not preclude the provider from attempting to collect the co-payment.

- (1) Co-payment is not required of the following members:
(A) Individuals under age 21. Each member's date of birth is available on the REVS system or through a commercial swipe card system.
(B) Members in nursing facilities and intermediate care facilities for the mentally retarded.
(C) Home and Community Based Service waiver members except for prescription drugs.
(D) Native Americans providing documentation of ethnicity in accordance with 317:35-5-25 who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.
(E) Individuals who are categorically eligible for SoonerCare through the Breast and Cervical Cancer Treatment program.
(F) Individuals receiving hospice care, as defined in section 1905(o) of the Social Security Act.

- (2) Co-payment is not required for the following services:
(A) Family planning services. Includes all contraceptives and services rendered.

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- (B) Emergency services provided in a hospital, clinic, office, or other facility.
- (C) Services furnished to pregnant women, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.
- (3) Co-payments are required in an amount not to exceed the federal allowable for the following:
 - (A) Inpatient hospital stays.
 - (B) Outpatient hospital visits.
 - (C) Ambulatory surgery visits including free-standing ambulatory surgery centers.
 - (D) Encounters with the following rendering providers:
 - (i) Physicians,
 - (ii) Advanced Practice Nurses,
 - (iii) Physician Assistants,
 - (iv) Optometrists,
 - (v) Home Health Agencies,
 - (vi) Certified Registered Nurse Anesthetists,
 - (vii) Anesthesiologist Assistants,
 - (viii) Durable Medical Equipment providers, and
 - (ix) Outpatient behavioral health providers.
 - (E) Prescription drugs.
 - (i) ~~Zero for preferred generics.~~
 - (ii) ~~\$0.65 for prescriptions having a SoonerCare allowable payment of \$0.00-\$10.00.~~
 - (iii) ~~\$1.20 for prescriptions having a SoonerCare allowable payment of \$10.01-\$25.00.~~
 - (iv) ~~\$2.40 for prescriptions having a SoonerCare allowable payment of \$25.01-\$50.00.~~
 - (v) ~~\$3.50 for prescriptions having a SoonerCare allowable payment of \$50.01 or more.~~
 - (F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.
- (4) Aggregate cost-sharing liabilities in a given calendar year may not exceed 5% of the member's gross annual income.

[OAR Docket #14-701; filed 7-8-14]

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

[OAR Docket #14-704]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-57. [AMENDED]

Part 4. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Program/Child Health Services

317:30-3-65.7. [AMENDED]

Subchapter 5. Individual Providers and Specialties

Part 45. Optometrists

317:30-5-432.1 [AMENDED]

(Reference APA WF #14-08)

AUTHORITY:

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

ADOPTION:

June 26, 2014

APPROVED BY GOVERNOR:

July 1, 2014

EFFECTIVE:

Immediately upon governor's approval or July 1, 2014, whichever is later.

EXPIRATION:

Effective through September 14, 2015, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's individual providers and specialties guidelines. These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

ANALYSIS:

Rules are amended to limit the number of payment for glasses to two per year. Any additional glasses beyond this limit must be prior authorized and determined to be medically necessary. These changes are needed in order to reduce the overall costs of the Medicaid program.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR JULY 1, 2014, WHICHEVER IS LATER AS SET FORTH IN 75 O.S., SECTION 253(F):

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

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

The following are general SoonerCare coverage guidelines for the categorically needy:

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

(A) Adult coverage for inpatient hospital stays as described at OAC 317:30-5-41.

(B) Coverage for members under 21 years of age is not limited. All admissions must be medically

necessary. All psychiatric admissions require prior authorization for an approved length of stay.

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

schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

- (G) Hearing services as outlined in OAC 317:30-3-65.9.
 - (H) Prescribed drugs.
 - (I) Outpatient Psychological services as outlined in OAC 317:30-5-275 through OAC 317:30-5-278.
 - (J) Inpatient Psychotherapy services and psychological testing as outlined in OAC 317:30-5-95 through OAC 317:30-5-97.
 - (K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.
 - (L) Inpatient hospital services.
 - (M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of SoonerCare.
 - (N) EPSDT services furnished in a qualified child health center.
- (14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members 21 years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least 30 days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.
 - (15) Physicians' services whether furnished in the office, the member's home, a hospital, a nursing facility, ~~ICF/MR/ICF/IID~~, or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four per month except when in connection with conditions as specified in OAC 317:30-5-9(b).
 - (16) Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. See applicable provider section for limitations to covered services for:
 - (A) Podiatrists' services
 - (B) Optometrists' services
 - (C) Psychologists' services
 - (D) Certified Registered Nurse Anesthetists
 - (E) Certified Nurse Midwives
 - (F) Advanced Practice Nurses
 - (G) Anesthesiologist Assistants
 - (17) Free-standing ambulatory surgery centers.
 - (18) Prescribed drugs not to exceed a total of six prescriptions with a limit of two brand name prescriptions per month. Exceptions to the six prescription limit are:
 - (A) unlimited medically necessary monthly prescriptions for:
 - (i) members under the age of 21 years; and

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- (ii) residents of Nursing Facilities or Intermediate Care Facilities for ~~the Mentally Retarded~~ Individuals with Intellectual Disabilities.
- (B) seven medically necessary generic prescriptions per month in addition to the six covered under the State Plan are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. These additional medically necessary prescriptions beyond the two brand name or thirteen total prescriptions are covered with prior authorization.
- (19) Rental and/or purchase of durable medical equipment.
- (20) Adaptive equipment, when prior authorized, for members residing in private ~~ICF/MR's~~ ICF/IID's.
- (21) Dental services for members residing in private ~~ICF/MR's~~ ICF/IID's in accordance with the scope of dental services for members under age 21.
- (22) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.
- (23) Standard medical supplies.
- (24) Eyeglasses under EPSDT for members under age 21. Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
- (25) Blood and blood fractions for members when administered on an outpatient basis.
- (26) Inpatient services for members age 65 or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
- (27) Nursing facility services, limited to members preauthorized and approved by OHCA for such care.
- (28) Inpatient psychiatric facility admissions for members under 21 are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.
- (29) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
- (30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last date of pregnancy.
- (31) Nursing facility services for members under 21 years of age.
- (32) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a R.N.
- (33) Part A deductible and Part B Medicare Coinsurance and/or deductible.
- (34) Home and Community Based Waiver Services for the intellectually disabled.
- (35) Home health services limited to 36 visits per year and standard supplies for 1 month in a 12-month period. The visits are limited to any combination of Registered Nurse and nurse aide visits, not to exceed 36 per year.
- (36) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:
- (A) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.
- (B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.
- (C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.
- (D) Finally, procedures considered experimental or investigational are not covered.
- (37) Home and community-based waiver services for intellectually disabled members who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).
- (38) Case Management services for the chronically and/or severely mentally ill.
- (39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.
- (40) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.
- (41) Early Intervention services for children ages 0-3.
- (42) Residential Behavior Management in therapeutic foster care setting.
- (43) Birthing center services.
- (44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services.
- (45) Home and Community-Based Waiver services for aged or physically disabled members.
- (46) Outpatient ambulatory services for members infected with tuberculosis.
- (47) Smoking and Tobacco Use Cessation Counseling for children and adults.
- (48) Services delivered to American Indians/Alaskan Natives in I/T/Us. Payment is made on an encounter basis.
- (49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

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

317:30-3-65.7. Vision services

(a) At a minimum, vision services include diagnosis and treatment for defects in vision, including eyeglasses once each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal (refer to OAC 317:30-5-2(b)(5) for amount, duration, and scope). Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary. The following schedule outlines the services required for vision services adopted by the OHCA.

- (1) Each newborn should have an assessment of the anatomy of the lids, alignment of the eyes and clarity of the ocular media with particular attention to documenting the presence of a normal red reflex. The history should document either a normal birth or other condition such as prematurity.
- (2) Red reflex and external appearance should be repeated and recorded on infants between one and four months of age.
- (3) At six months of age, repeat red reflex and external exam and add an evaluation of ocular alignment with a corneal light reflex test.
- (4) One screen should occur between nine and 12 months to mirror the six month screening.
- (5) One screening from age three to five including alignment and an acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- (6) Objective visual acuity testing should be provided at ages five through ten, and once during ages 11 through 18. All other years are subjective by history.

(b) Interperiodic vision examinations are allowed at intervals outside the periodicity schedule when a vision condition is suspected.

(c) SoonerCare provides frames when medically necessary. Frames are expected to last at least one year and must be reusable. If a lens prescription changes, the same frame must be used if possible. Payment for frames includes the dispensing fee.

(d) SoonerCare reimbursement for frames or lenses represents payment in full. No difference can be collected from the patient, family or guardians.

(e) Replacement of or additional lenses and frames are allowed when medically necessary. Prior authorization is not required; unless the number of glasses exceeds two per year, however, the provider must always document in the patient record the reason for the replacement or additional eyeglasses. The OHCA or its designated agent will conduct ongoing monitoring of replacement frequencies to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.

(f) Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Progressive lenses, trifocals, photochromic lenses and tints for children require prior authorization and medical necessity. Polycarbonate lenses are covered for children when medically necessary. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(g) Progressive lenses, aspheric lenses, tints, coatings and photochromic lenses for adults are not compensable and may be billed to the patient.

(h) Replacement of lenses and frames due to abuse and neglect by the member is not covered.

(i) Bandage contact lenses are a covered benefit for adults and children. Contact lenses for medically necessary treatment of conditions such as aphakia, keratoconus, following keratoplasty, aniseikonia/anisometropia or albinism are a covered benefit for adults and children. Other contact lenses for children require prior authorization and medical necessity.

[OAR Docket #14-704; filed 7-8-14]

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 45. OPTOMETRISTS

317:30-5-432.1. Corrective lenses and optical supplies

(a) Payment will be made for children for lenses, frames, low vision aids and certain tints when medically necessary including to protect children with monocular vision. Coverage includes one set of lenses and frames per year. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(b) Corrective lenses must be based on medical need. Medical need includes a change in prescription or replacement due to normal lens wear.

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

[OAR Docket #14-706]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 21. Outpatient Behavioral Health Services
317:30-5-241.2. [AMENDED]
317:30-5-241.3. [AMENDED]
(Reference APA WF # 14-10)

AUTHORITY:
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.130; 42 CFR 440.230

ADOPTION:
June 26, 2014

Emergency Adoptions

APPROVED BY GOVERNOR:

July 1, 2014

EFFECTIVE:

Immediately upon Governor's approval or August 1, 2014, whichever is later.

EXPIRATION:

Effective through September 11, 2014, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's individual provider and specialties guidelines. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services' operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Department is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program.

ANALYSIS:

Outpatient behavioral health rules are amended to add additional eligibility criteria required in order to receive psychosocial rehabilitation (PSR) services. Adult PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; are residing in residential care facilities; or are receiving services through a specialty court program. Children's PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; have a current Individual Education Plan (IEP) or 504 Plan for emotional disturbance; or have been evaluated by a school psychologist, licensed psychologist, or psychiatrist and determined to be "at risk". Narrowing the eligibility criteria for PSR services comports with the Federal definition of rehabilitative services found in 42 CFR 440.130(d) which defines them as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts or maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level."

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(F), AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR AUGUST 1, 2014, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-241.2. Psychotherapy

(a) Psychotherapy.

(1) **Definition.** Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic

communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change.

(2) **Definition.** Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) **Qualified professionals.** Psychotherapy must be provided by a Licensed Behavioral Health Professional (LBHP) in a setting that protects and assures confidentiality. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities.

(4) **Limitations.** A maximum of 6 units per day per member is compensable. Except for psychotherapy involving interactive complexity as described in this Section, only the member and the Licensed Behavioral Health Professional (LBHP) should be present during the session.

(b) Group Psychotherapy.

(1) **Definition.** Group psychotherapy is a method of treating behavioral disorders using the interaction between

the LBHP and two or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under Behavioral Health Rehabilitation Services.

(2) **Group sizes.** Group Psychotherapy is limited to a total of eight adult (18 and over) individuals except when the individuals are residents of an ICF/MR where the maximum group size is six. For all children under the age of 18, the total group size is limited to six.

(3) **Multi-family and conjoint family therapy.** Sessions are limited to a maximum of eight families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

(4) **Qualified professionals.** Group psychotherapy will be provided by a LBHP. Group Psychotherapy must take place in a confidential setting limited to the LBHP, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Limitations.** A maximum of 12 units per day per member is compensable.

(c) **Family Psychotherapy.**

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

(2) **Qualified professionals.** Family Psychotherapy must be provided by a LBHP.

(3) **Limitations.** A maximum of 12 units per day per member/family unit is compensable. The provider may not bill any time associated with note taking and/or medical record upkeep. The provider may only bill the time spent in direct face-to-face contact. Provider must comply with documentation requirements listed in OAC 317:30-5-248.

(d) **Multi-Systemic Therapy (MST).**

(1) **Definition.** MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Case loads are kept low due to the intensity of the services provided.

(2) **Qualified professionals.** Masters level professionals who work with a team that may include bachelor level staff.

(3) **Documentation requirements.** Providers must comply with documentation requirements in 317:30-5-248.

(4) **Service limitations.** Partial billing is not allowed, when only one service is provided in a day, providers should not bill for services performed for less than 8 minutes.

(e) **Children/Adolescent Partial Hospitalization Program (PHP).**

(1) **Definition.** Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve the member's condition and functional level and to prevent relapse or hospitalization and (3) Include the following:

(A) Assessment, diagnostic and treatment plan services for mental illness and/or substance abuse disorders provided by LBHPs.

(B) Individual/Group/Family (primary purpose is treatment of the member's condition) psychotherapies provided by LBHPs.

(C) Substance abuse specific services are provided by LBHPs qualified to provide these services.

(D) Drugs and biologicals furnished for therapeutic purposes.

(E) Family counseling, the primary purpose of which is treatment of the member's condition.

(F) Behavioral health rehabilitation training and education services to the extent the training and educational activities are closely and clearly related to the member's care and treatment, provided by a Behavioral Health Rehabilitation Specialist (BHRS), Certified Alcohol and Drug Counselor (CADC) or LBHP who meets the professional requirements listed in 317:30-5-240.3 or a Certified Behavioral Health Case Manager II.

(G) Care Coordination of behavioral health services provided by certified behavioral health case managers.

(2) **Qualified professionals.**

(A) All services in the PHP are provided by a clinical team, consisting of the following required professionals:

- (i) A licensed physician;
- (ii) Registered nurse; and
- (iii) One or more of the licensed behavioral health professionals (LBHP) listed in 30-5-240.3(a).

(B) The clinical team may also include any of the following paraprofessionals:

- (i) Behavioral Health Rehabilitation Specialist; or
- (ii) Certified Behavioral Health Case Manager.

(C) The treatment plan is directed under the supervision of a physician and the number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program.

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(3) **Qualified providers.** Provider agencies for PHP must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of the enrolled agency.

(4) **Limitations.** Services are limited to children 0-20 only. Services must be offered at a minimum of 3 hours per day, 5 days per week. Therapeutic services are limited to 4 billable hours per day. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered, those services are separately billable. Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning. Occupational, Physical and Speech therapy will be provided by the Independent School District (ISD).

(5) **Service requirements.**

(A) Therapeutic Services are to include the following:

- (i) Psychiatrist/physician face-to-face visit 2 times per month;
- (ii) Crisis management services available 24 hours a day, 7 days a week;

(B) Psychotherapies to be provided a minimum of four (4) hours per week and include the following:

- (i) Individual therapy - a minimum of 1 session per week;
- (ii) Family therapy - a minimum of 1 session per week; and
- (iii) Group therapy - a minimum of 2 sessions per week;

(C) Interchangeable services which include the following:

- (i) Behavioral Health Case Management (face-to-face);
- (ii) Behavioral health rehabilitation services/alcohol and other drug abuse education;
- (iii) Medication Training and Support; and
- (iv) Expressive therapy.

(6) **Documentation requirements.** Documentation needs to specify active involvement of the member's family, caretakers, or significant others involved in the individual's treatment. A nursing health assessment must be completed within 24 hours of admission. A physical examination and medical history must be coordinated with the Primary Care Physician. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to Section OAC 317:30-5-248.

(7) **Staffing requirements.** Staffing requirements must consist of the following:

(A) RN trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available onsite during program hours to provide necessary nursing care and/or psychiatric nursing care (1 RN at a minimum

can be backed up by an LPN but an RN must always be onsite). Nursing staff administers medications, follows up with families on medication compliance, and restraint assessments.

(B) Medical director must be a licensed psychiatrist.

(C) A psychiatrist/physician must be available 24 hours a day, 7 days a week.

(f) **Children/Adolescent Day Treatment Program.**

(1) **Definition.** Day Treatment Programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.

(2) **Qualified professionals.** All services in Day Treatment are provided by a team, which must be composed of one or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP), a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Services are directed by an LBHP.

(3) **Qualified providers.** Provider agencies for Day Treatment must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA).

(4) **Limitations.** Services must be offered at a minimum of 4 days per week at least 3 hours per day. Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning.

(5) **Service requirements.** On-call crisis intervention services must be available 24 hours a day, 7 days a week (When members served have psychiatric needs, psychiatric services are available which include the availability of a psychiatrist 24 hours a day, 7 days a week. A psychiatrist can be available either on site or on call but must be available at all times). Day treatment program will provide assessment and diagnostic services and/or medication monitoring, when necessary.

(A) Treatment activities are to include the following every week:

- (i) Family therapy at least one hour per week (additional hours of FT may be substituted for other day treatment services);
- (ii) Group therapy at least two hours per week; and
- (iii) Individual therapy at least one hour per week.

(B) Additional services are to include at least one of the following services per day:

- (i) Medication training and support (nursing) once monthly if on medications;

- (ii) Behavioral health rehabilitation services to include alcohol and other drug education if the child meets the criteria established in 317:30-5-241.3 and is clinically necessary and appropriate
 - (iii) Behavioral health case management as needed and part of weekly hours for member;
 - (iv) Occupational therapy as needed and part of weekly hours for member; and
 - (v) Expressive therapy as needed and part of weekly hours for the member.
- (6) **Documentation requirements.** Service plans are required every three (3) months.

317:30-5-241.3. Behavioral Health Rehabilitation (BHR) services

(a) **Definition.** Behavioral Health Rehabilitation (BHR) services are goal oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the members to their best possible mental and/or behavioral health functioning. BHR services must be coordinated in a manner that is in the best interest of the member and may be provided in a variety of community and/or professional settings that protect and assure confidentiality. For purposes of this Section, BHR includes Psychosocial Rehabilitation, Outpatient Substance Abuse Rehabilitation, and Medication Training and Support.

(b) **Psychosocial Rehabilitation (PSR).**

(1) **Definition.** PSR services are face-to-face Behavioral Health Rehabilitation 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. Rehabilitation services may be provided individually or in group sessions, and they take the format of curriculum based education and skills training.

(2) **Clinical restrictions.** This service is generally performed with only the members and the qualified provider, but may include a member and the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery based curriculum. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance abuse, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires a licensed provider.

(3) **Qualified providers.** A BHRSCertified Behavioral Health Case Manager II (CM II), CADC, and LBHP may perform PSR, following development of a service plan and treatment curriculum approved by a LBHP. PSR staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE or trauma informed methodology. The BHRSCM II and CADC must have immediate access to

a fully licensed LBHP who can provide clinical oversight ~~of the BHR~~ and collaborate with the BHRScqualified PSR provider in the provision of services. A minimum of one monthly face-to-face consultation with a fully licensed LBHP is required.

(4) **Group sizes.** The maximum staffing ratio is fourteen members for each qualified provider for adults and eight to one for children under the age of eighteen.

(5) **Limitations.**

(A) **Transportation.** Travel time to and from PSR treatment is not compensable. Group PSR services do not qualify for the OHCA transportation program, but OHCA will arrange for transportation for those who require specialized transportation equipment.

(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, PSR services may take place in settings away from the outpatient behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(D) **Eligibility for PSR services.** ~~PSR services are intended for adults with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED), and children with other emotional or behavioral disorders. The following members are not eligible for PSR services:~~ All PSR services require prior authorization and must meet established medical necessity criteria.

(i) Adults. PSR services for adults are limited to members who have a history of psychiatric hospitalization or admissions to crisis centers, have been determined disabled by the SSA for mental health reasons, are residing in residential care facilities or are receiving services through a specialty court program.

(ii) Children. PSR services for children are limited to members who have a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the SSA for mental health reasons; have a current Individual Education Plan (IEP) or 504 Plan for emotional disturbance; or have been evaluated by a school psychologist, licensed psychologist or psychiatrist and determined to be "at risk" as outlined in the Prior Authorization Manual.

(iii) The following members are not eligible for PSR services:

(i) Residents of ICF/MR facilities, unless authorized by OHCA or its designated agent;

(ii) children under age 6, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based

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- on the criteria in (5)(D)(ii) above as well as a finding of medical necessity;
- (~~iii~~III) children receiving RBMS in a group home or therapeutic foster home, unless authorized by OHCA or its designated agent;
 - (~~iv~~IV) inmates of public institutions;
 - (~~v~~V) members residing in inpatient hospitals or IMDs; and
 - (~~vi~~VI) members residing in nursing facilities.
- (E) **Billing limits.** PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to compliment more intensive behavioral health therapies. Service limits are based on the member's needs according to the CAR or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits. PSR services authorized under this Section are separate and distinct from, but should not duplicate the structured services required for children residing in group home or therapeutic foster care settings, or receiving services in Day Treatment or Partial Hospitalization Programs. Children under an ODMHSAS Systems of Care program and adults residing in residential care facilities may be prior authorized additional units as part of an intensive transition period. PSR is billed in unit increments of 15 minutes with the following limits:
- (i) **Group PSR.** The maximum is 24 units per day for adults and 16 units per day for children.
 - (ii) **Individual PSR.** The maximum is six units per day.
 - (iii) **Per-Member service levels and limits.** Unless otherwise specified, group and/or individual PSR services provided in combination may not exceed the monthly limits established in the individual's prior authorization. Limits on PSR services are established based on the level for which the member has been approved. There are no limits on PSR services for individuals determined to be Level 4.
 - (iv) **EPSDT.** Pursuant to OAC 317:30-3-65 et seq., billing limits may be exceeded or may not apply if documentation demonstrates that the requested services are medically necessary and are needed to correct or ameliorate defects, physical or behavioral illnesses or conditions discovered through a screening tool approved by OHCA or its designated agent. The OHCA has produced forms for documenting an EPSDT child health checkup screening which the provider can access on the OHCA website.
- (F) **Progress Notes.** In accordance with OAC 317:30-5-241.1, the behavioral health service plan developed by the LBHP must include the member's

strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level. Progress notes for intensive and skills training mental health, substance abuse or integrated programs may be in the form of daily summary or weekly summary notes and must include the following:

- (i) Curriculum sessions attended each day and/or dates attending during the week;
 - (ii) Start and stop times for each day attended and the physical location in which the service was rendered;
 - (iii) Specific goal(s) and objectives addressed during the week;
 - (iv) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;
 - (v) Member satisfaction with staff intervention(s);
 - (vi) Progress, or barrier to, made towards goals, objectives;
 - (vii) New goal(s) or objective(s) identified;
 - (viii) Signature of the lead qualified provider; and
 - (ix) Credentials of the lead qualified provider;
- (G) **Additional documentation requirements.**
- (i) a list/log/sign in sheet of participants for each Group rehabilitative session and facilitating qualified provider must be maintained; and
 - (ii) Documentation of ongoing consultation and/or collaboration with a LBHP related to the provision of PSR services.
- (H) **Non-Covered Services.** The following services are not considered BHR and are not reimbursable:
- (i) Room and board;
 - (ii) educational costs;
 - (iii) supported employment; and
 - (iv) respite.
- (c) **Outpatient Substance Abuse Rehabilitation Services.**
- (1) **Definition.** Covered outpatient substance abuse rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance abuse rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. Rehabilitation services may be provided

individually or in group sessions, and they take the format of curriculum based education and skills training.

(2) **Limitations.** Group sessions may not be provided in the home.

(3) **Eligibility.** Members eligible for substance abuse rehabilitation services must meet the criteria for ASAM PCC Treatment Level 1, Outpatient Treatment.

(4) **Qualified providers.** ~~BHRSCM II~~, CADC or LBHP.

(5) **Billing limits.** Group rehabilitation is limited to two (2) hours per session. Group and/or individual outpatient substance abuse rehabilitation services provided in combination may not exceed the monthly limits established in the individual's prior authorization. Limits on services are established based on the level for which the member has been approved. There are no limits on substance abuse rehabilitation services for individuals determined to be Level 4.

(6) **Documentation requirements.** Documentation requirements are the same as for PSR services as set forth in 30-5-241.3(b)(5)(F).

(d) **Medication training and support.**

(1) **Definition.** Medication Training and Support is a documented review and educational session by a registered nurse, advanced practice 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 medical or clinical record. 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) Two units are allowed per month per patient.

(C) Medication Training & Support is not allowed to be billed on the same day as an evaluation and management (E/M) service provided by a psychiatrist.

(3) **Qualified professionals.** Must be provided by a licensed registered nurse, an advanced practice nurse, or a physician assistant as a direct service under the supervision of a physician.

(4) **Documentation requirements - Medication Training and Support** documented review must focus on:

- (A) a member's response to medication;
- (B) compliance with the medication regimen;
- (C) medication benefits and side effects;
- (D) vital signs, which include pulse, blood pressure and respiration; and

(E) documented within the progress notes/medication record.

[OAR Docket #14-706; filed 7-8-14]

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

[OAR Docket #14-698]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 35. Rural Health Clinics

317:30-5-355.1 [AMENDED]

317:30-5-356 [AMENDED]

317:30-5-357 [AMENDED]

317:30-5-361 [AMENDED]

Part 75. Federally Qualified Health Centers

317:30-5-664.3 [AMENDED]

317:30-5-664.4 [REVOKED]

317:30-5-664.12 [AMENDED]

(Reference APA WF # 14-02)

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 440.20; CFR 447.371; 42 CFR 440.365

ADOPTION:

June 26, 2014

APPROVED BY GOVERNOR:

July 1, 2014

EFFECTIVE:

Immediately upon governor's approval or July 1, 2014, whichever is later.

EXPIRATION:

Effective through September 14, 2015, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's individual provider and specialties guidelines. These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

ANALYSIS:

Rules are revised to limit encounters within Federal Qualified Health Centers (FQHC) and Rural Health Clinic Services (RHC) to one encounter per member per day as well as limit encounters to a total of four visits per member per month. This change in procedure regarding encounters in FQHCs and RHCs is needed in order to reduce overall costs of the Medicaid program.

CONTACT PERSON:

Tywanda Cox at (405)522-7153

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR JULY 1, 2014, WHICHEVER IS LATER AS SET FORTH IN 75 O.S., SECTION 253(F):

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 35. RURAL HEALTH CLINICS

317:30-5-355.1. Definition of services

The RHC benefit package, as described in Title 42 of the Code of Federal Regulations (CFR), part 440.20, consists of two components: RHC Services and Other Ambulatory Services.

(1) **RHC services.** RHC services are covered when furnished to a member at the clinic or other location, including the member's place of residence. These services are described in this Section.

(A) **Core services.** As set out in Federal Regulations at 42 CFR 440.20(b), RHC "core" services include, but are not limited to:

- (i) Physician's services;
- (ii) Services and supplies incident to a physician's services;
- (iii) Services of advanced practice nurses (APNs), physician assistants (PAs), nurse midwives (NMs) or specialized advanced practice nurse practitioners;
- (iv) Services and supplies incident to the services of APNs and PAs (including services furnished by nurse midwives);
- (v) Visiting nurse services to the homebound;
- (vi) Clinical psychologist (CP) and clinical social worker (CSW) services;
- (vii) Services and supplies incident to the services of CPs and CSWs.

(B) **Physicians' services.** In addition to the professional services of a physician, and services provided by an APN, PA and NMW which would be covered as RHC services under Medicare, certain primary preventive services are covered under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of a RHC practitioner who is a clinic employee:

- (i) prenatal and postpartum care;
- (ii) screening examination under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for members under 21;
- (iii) family planning services;
- (iv) medically necessary screening mammography and follow-up mammograms when medically necessary.

(C) **Services and supplies "incident to".** Services and supplies incident to the service of a physician, physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker are covered if the service or supply is:

- (i) a type commonly furnished in physicians' offices;
- (ii) a type commonly rendered either without charge or included in the rural health clinic's bill;

(iii) furnished as an incidental, although integral, part of a physician's professional services;

(iv) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(D) **Visiting nurse services.** Visiting nurse services are covered if:

- (i) the RHC is located in an area in which the Centers for Medicare and Medicaid Services (CMS) has determined there is a shortage of home health agencies;
- (ii) the services are rendered to members who are homebound;
- (iii) the member is furnished nursing care on a part time or intermittent basis by a registered nurse, licensed practical nurse or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and
- (iv) the services are furnished under a written plan of treatment.

(E) **RHC encounter.** RHC "core" services (including preventive services, i.e., prenatal, EPSDT or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and a RHC health professional (i.e., physicians, physician assistants, advanced practice nurses, nurse midwives, clinical psychologists and clinical social workers). Encounters with more than one health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Payment is made for one encounter per member per day. Medical review will be required for additional visits for children. Payment is also limited to four visits per member per month for adults.

(F) **Off-site services.** RHC services provided off-site of the clinic are covered as long as the RHC has a compensation arrangement with the RHC practitioner that SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The rural health clinic must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the rural health clinic services provided off-site are to be billed to SoonerCare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) **Other ambulatory services.** A Rural Health Clinic must provide other items and services which are not "RHC services" as described in (a)(1) of this Section, and are separately billable to the SoonerCare program. Coverage of services are based upon the scope of coverage under the SoonerCare program.

(A) Other ambulatory services include, but are not limited to:

- (i) dental services for members under age 21;
- (ii) optometric services;
- (iii) clinical lab tests performed in the RHC lab, including the lab tests required for RHC certification;
- (iv) technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);
- (v) durable medical equipment;
- (vi) emergency ambulance transportation;
- (vii) prescribed drugs;
- (viii) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
- (ix) specialized laboratory services furnished away from the clinic;
- (x) inpatient services;
- (xi) outpatient hospital services.

(B) Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist or optometric services by a licensed optometrist for members under age 21. Encounters are billed as one of the following:

- (i) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.
- (ii) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.
- (iii) **Visual analysis.** Visual analysis (initial or yearly) for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Glasses must be billed separately. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(C) Services listed in (a)(2)(A), (v)-(viii), of this Section, furnished on-site, require separate provider agreements with the OHCA. Service item (a)(2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions

of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

(D) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

317:30-5-356. Coverage for adults

Payment is made to rural health clinics for adult services as set forth in this Section.

(1) **RHC services.** ~~Payment is limited to four visits per member per month.~~ Payment is made for one encounter per member per day. Payment is also limited to four visits per member per month. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-65.2 for exceptions to ~~this~~ the four visit limit for children under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Additional preventive service exceptions include:

(A) **Obstetrical care.** A Rural Health Clinic should have a written contract with its physician, nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for rural health and non-rural health clinic (other ambulatory) services.

(i) If the clinic compensates the physician, nurse midwife or advanced practice nurse to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.

(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).

(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one of the four RHC visits per month.

(2) **Other ambulatory services.** Services defined as "other ambulatory" services are not considered a part of a

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RHC visit and are therefore billable to the SoonerCare program by the RHC or provider of service on the appropriate claim forms. Other ambulatory services are subject to the same scope of coverage as other SoonerCare services billed to the program, i.e., limited adult services and some services for under 21 subject to same prior authorization process. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

317:30-5-357. Coverage for children

Coverage for rural health clinic services and other ambulatory services for children include the same services as for adults in addition to the following:

- (1) The receipt of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) examination by a Medicaid eligible individual under age 21 renders that individual child eligible for all necessary follow-up care, whether or not the medically necessary services are covered under the Medicaid program. An EPSDT exam performed by a RHC must be billed on the appropriate claim form with the appropriate Preventative Medicine procedure code from the Current Procedural Terminology Manual (CPT). If an EPSDT screening is billed, a RHC encounter should not be billed on the same day. Refer to OAC 317:30-3-47 through 317:30-3-54 for coverages under EPSDT).
- (2) Under EPSDT, coverage is allowed for visual screenings and eyeglasses to correct visual defects. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
- (3) An EPSDT screening is considered a comprehensive examination. A provider billing the Medicaid program for an EPSDT screen may not bill any other visits for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. Additional services such as tests, immunizations, etc., required at the time of screening may be billed independently from the screening.
- (4) The administration fee for immunizations should be billed if provided at the same time as a scheduled EPSDT examination.
- (5) Payment may be made directly to the RHC for the professional services of physician assistants performing EPSDT screenings within the certified RHC. The claim form must include the signature of the supervising physician.

317:30-5-361. Billing

(a) **Encounters.** Payment is made for one ~~type of~~ encounter per member per day. Medical review will be required for additional visits for children. Payment is also limited to four visits per member per month for adults. Rural health clinics must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

- (1) **RHC.** The appropriate revenue code is required. No HCPC or CPT code is required.
 - (2) **Mental health.** Mental health services must include a revenue code and a HCPCS code.
 - (3) **Obstetrical care.** The appropriate revenue code and HCPCS code are required. The date the member is first seen is required. The primary pregnancy diagnosis code is also required. Secondary diagnosis codes are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.
 - (4) **Family planning.** Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.
 - (5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the Current Procedural Terminology Manual (CPT).
 - (6) **Dental.** Dental services for children must be billed on the appropriate dental claim form.
 - (7) **Visual analysis.** Optometric services for children are billed using the appropriate revenue code and a HCPCS code.
- (b) **Services billed separately from encounters.** Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges.
- (1) **Laboratory.** The rural health clinic must be CLIA certified for specialized laboratory services performed. Laboratory services must be itemized separately using the appropriate CPT or HCPCS code.
 - (2) **Radiology.** Radiology must be identified using the appropriate CPT or HCPC code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.
 - (3) **Immunizations.** The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.
 - (4) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required. The following are examples:
 - (A) DepoProvera 150 mg. (Medroxyprogesterone Acetate).
 - (B) Insertion and implantation of a subdermal contraceptive device.
 - (C) Removal, implantable contraceptive devices.

- (D) Removal, with reinsertion, implantable contraceptive device.
- (E) Insertion of intrauterine device (IUD).
- (F) Removal of intrauterine device.
- (G) ParaGard IUD.
- (H) Progestasert IUD.

(5) **Glasses.** Glasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(6) **Telemedicine.** The originating site facility fee for telemedicine services is not a rural health clinic service. When a rural health clinic serves as the originating site, the originating site facility fee is paid separately from the clinic's all-inclusive rate.

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.3. Health Center encounters

(a) Health Center encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by the authorized health care professional on the approved FQHC state plan pages within the scope of their licensure trigger a PPS encounter rate.

(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a Health Center within a 24-hour period ending at midnight, as documented in the member's medical record.

(c) ~~For information about multiple encounters, refer to OAC 317:30-5-664.4.~~ A Health Center may bill for one medically necessary encounter per 24 hour period. Medical review will be required for additional visits for children. Payment is limited to four visits per member per month for adults.

(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:

- (1) medical;
- (2) diagnostic;
- (3) dental, medical and behavioral health screenings;
- (4) vision;
- (5) physical therapy;
- (6) occupational therapy;
- (7) podiatry;
- (8) behavioral health;
- (9) speech;
- (10) hearing;
- (11) medically necessary Health Center encounters with a RN or LPN and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3);

(12) any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the Health Center's scope of services when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to a physician's professional service are reimbursable within the encounter if the service or supply is:

- (1) of a type commonly furnished in physicians' offices;
- (2) of a type commonly rendered either without a charge or included in the health clinic's bill;
- (3) furnished as an incidental, although integral, part of a physician's professional services;
- (4) furnished under the direct, personal supervision of a physician; and
- (5) in the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

317:30-5-664.4. Multiple encounters at Health Centers [REVOKED]

~~(a) A Health Center may bill for more than one medically necessary encounter per 24 hour period under certain conditions.~~

~~(b) It is intended that multiple medically necessary encounters will occur on an infrequent basis.~~

~~(c) A Center may not develop Center procedures that routinely involve multiple encounters for a single date of service, unless medical necessity warrant multiple encounters.~~

~~(d) Each service must have distinctly different diagnoses in order to meet the criteria for multiple encounters. For example, a medical visit and a dental visit on the same day are considered different services with distinctly different diagnoses.~~

~~(e) Similar services, even when provided by two different health care practitioners, are not considered multiple encounters.~~

317:30-5-664.12. Determination of Health Center PPS rate

(a) **Methodology.** The methodology for establishing each facility's PPS rate is found in Attachment 4.19 B of the OHCA's State Plan, as amended effective January 1, 2001, and incorporated herein by reference.

(b) **Scope of service adjustment.** If a Center significantly changes its scope of services, the Center may request in writing that new baseline encounter rates be determined. Adjustments to encounter rates are made ~~only if the change in the scope of services results in the inclusion of behavioral health services or dental services or a difference of at least five percent from the Center's current costs (other than overhead) if it is determined that a significant change in the scope-of-service has occurred which impacts the base rate, as indicated within the State Plan.~~ If there is a change in scope-of-service, it is the responsibility of the FQHC to request OHCA to review services that have

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~~had a change to the scope-of-service. The OHCA may initiate a rate adjustment in accordance with procedures in the State Plan, based on audited financial statements or cost reports, if the scope of services has been modified to include behavioral health services or dental services or would otherwise result in a change of at least five percent from the Center's current rate. If a new rate is set, the rate change takes effect on the latter of the change of services date or the date of application to the OHCA for rate change will be effective on the date the change in scope-of-service was implemented.~~

[OAR Docket #14-698; filed 7-8-14]

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

[OAR Docket #14-700]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 3. Hospitals

317:30-5-56. [AMENDED]

(Reference APA WF # 14-04)

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 412.50 through 42 CFR 412.154

ADOPTION:

June 26, 2014

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July 1, 2014

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SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's individual provider and specialties guidelines. These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

ANALYSIS:

Rules are amended to reduce/deny payment for preventable readmissions that occur within 30 days from discharge. The current policy reviews readmissions occurring within 15 days of prior acute care admissions or a related condition to determine medical necessity and appropriateness of care. If it is determined either or both admissions may be inappropriate, payment for either or both admissions may be denied. This change in policy regarding readmissions is needed in order to reduce overall costs of the Medicaid program.

CONTACT PERSON:

Tywanda Cox at (405)522-7153

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(F), WITH A LATER EFFECTIVE DATE OF OCTOBER 1, 2014:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-56. Utilization review

All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment. In addition to the random sample of all admissions, retrospective review policy includes the following:

(1) Hospital stays less than three days in length will be reviewed for medical necessity and appropriateness of care. (Discharges involving healthy mother and healthy newborns may be excluded from this review requirement.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient stay will be denied.

(2) Cases which indicate transfer from one acute care hospital to another will be monitored to help ensure that payment is not made for inappropriate transfers.

(3) Readmissions occurring within ~~15~~30 days of prior acute care admission for a related condition will be reviewed to determine medical necessity and appropriateness of care or whether the readmission was potentially preventable. If it is determined that either or both admissions were unnecessary or inappropriate or potentially preventable, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the OHCA.

[OAR Docket #14-700; filed 7-8-14]

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

[OAR Docket #14-699]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 9. Long Term Care Facilities

317:30-5-126 [AMENDED]

(Reference APA WF # 14-03)

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 483.12

ADOPTION:

June 26, 2014

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July 1, 2014

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SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's individual provider and specialties guidelines. These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

ANALYSIS:

Rules are revoked to eliminate payment for hospital leave to nursing facilities and ICF/IIDs. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital. This change in procedure regarding payment to nursing facilities is needed in order to reduce overall costs of the Medicaid program.

CONTACT PERSON:

Tywanda Cox at (405)522-7153

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR JULY 1, 2014, WHICHEVER IS LATER AS SET FORTH IN 75 O.S., SECTION 253(F):

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

317:30-5-126. Therapeutic leave and Hospital leave

Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made.

- (1) Effective July 1, 1994, the nursing facility may receive payment for a maximum of seven (7) days of therapeutic leave per calendar year for each recipient to reserve the bed. Claims for therapeutic leave are to be submitted on Form ADM41 (Long Term Care Claim Form).
- (2) ~~Effective January 1, 1996, the nursing facility may receive payment for a maximum of five days of hospital leave per calendar year for each recipient to reserve the~~

~~bed when the patient is admitted to a licensed hospital. No payment shall be made to a nursing facility for hospital leave.~~

(3) The Intermediate Care Facility for the Mentally Retarded (ICF/MR) may receive payment for a maximum of 60 days of therapeutic leave per calendar year for each recipient to reserve a bed. No more than 14 consecutive days of therapeutic leave may be claimed per absence. Recipients approved for ICF/MR on or after July 1 of the year will only be eligible for 30 days of therapeutic leave during the remainder of that year. Claims for therapeutic leave are to be submitted on Form Adm-41. No payment shall be made for hospital leave.

(4) Midnight is the time used to determine whether a patient is present or absent from the facility. The day of discharge for therapeutic leave is counted as the first day of leave, but the day of return from such leave is not counted. ~~For hospital leave, the day of hospital admission is the first day of leave. The day the patient is discharged from the hospital is not counted as a leave day.~~

(5) Therapeutic ~~and~~ hospital leave balances are recorded on the Medicaid Management Information System (MMIS) recipient record based on the Form Adm-41 submitted by the facility. When a patient moves to another facility, it is the responsibility of the transferring facility to forward the patient's leave records to the receiving facility. Forms are available in the local county OKDHS office.

[OAR Docket #14-699; filed 7-8-14]

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

[OAR Docket #14-703]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 17. Medical Suppliers

317:30-5-211.11 [AMENDED]

317:30-5-211.12 [AMENDED]

(Reference APA WF # 14-07)

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 424.57(c)

ADOPTION:

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SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

Emergency Adoptions

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's individual providers and specialties guidelines. These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

ANALYSIS:

Oxygen and oxygen equipment rules are revised to require a prior authorization after the initial three months. In addition, rules are revised to clarify arterial blood gas analysis (ABG) and pulse oximetry testing and Certificate of Medical Necessity requirements.

CONTACT PERSON:

Tywanda Cox at (405)522-7153

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(F), AND EFFECTIVE IMMEDIATELY UPON APPROVAL BY THE GOVERNOR OR AUGUST 1, 2014, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 17. MEDICAL SUPPLIERS

317:30-5-211.11. Oxygen and oxygen equipment

(a) **Medical necessity.** Oxygen and oxygen supplies are covered when medically necessary. Medical necessity is determined from results of arterial blood gas analysis (ABG) or pulse oximetry (SaO₂) tests (pO₂). ABG data are not required for children, but may be used if otherwise available. The test results to document Medical Necessity must be within 30 days of the date of the physician's prescription-qualified medical practitioner's Certificate of Medical Necessity. Prior authorization is required after the initial three months of billing whether qualifying tests were done at rest, during sleep, or during exercise. Appropriate documentation of ABG or SaO₂ data from the member's chart should be attached to the prior authorization request (PAR). A copy of a report from an inpatient or outpatient hospital or emergency room setting will meet the requirement.

(1) For initial certification for oxygen, the ABG study or oximetry analysis used to determine medical necessity may not be performed by the DMEPOS or a related corporation. In addition, neither the study nor the analysis may be performed by a physician with a significant ownership interest in the DMEPOS performing such tests. These prohibitions include relationships through blood or marriage. A referring physician may perform the test in his/her office as part of routine member care. The ABG or oximetry test used to determine medical necessity must be performed by a medical professional qualified to conduct such testing.

The test may not be performed or paid for by a DMEPOS supplier, or a related corporation. A referring qualified medical practitioner may perform the test in his/her office as part of routine member care.

(2) Initial certification is for no more than three months. Except in the case of sleep induced hypoxemia, ABG or oximetry is required within the third month of the initial certification period if the member has a continued need for supplemental oxygen. Re certification will be required every 12 months.

(A) Adults. Initial requests for oxygen must include ABG or resting oximetry results. The arterial blood saturation can not exceed 89% at rest on room air; the pO₂ level can not exceed 59mm Hg.

(B) Children. Requests for oxygen for children that do not meet the following requirements should include documentation of the medical necessity based on the child's clinical condition and are considered on a case by case basis. Members 20 years of age or less must meet the following requirements:

(i) birth through three years, SaO₂ level equal to or less than 94%; and

(ii) ages four and above, SaO₂ level equal to or less than 90%. In addition to ABG data, the following three tests are acceptable for determining medical necessity for oxygen prescription:

(A) At rest and awake "spot oximetry."

(B) During sleep:

(i) Overnight Sleep Oximetry done inpatient or at home.

(ii) Polysomnogram, which may be used only if medically necessary for concurrent evaluation of another condition while in a chronic stable state.

(C) During exercise with all three of the following performed in the same testing session.

(i) At rest, off oxygen showing a non-qualifying result.

(ii) During exercise, off oxygen showing a qualifying event.

(iii) During exercise, on oxygen showing improvement over test (C) ii above.

(3) Certification criteria:

(A) All qualifying testing must meet the following criteria:

(B) Adults. Initial requests for oxygen must include ABG or resting oximetry results. At rest and on room air, the arterial blood saturation (SaO₂) cannot exceed 89% or the pO₂ cannot exceed 59mm Hg.

(C) Children. Members 20 years of age or less must meet the following requirements:

(i) birth through three years, SaO₂ equal to or less than 94%; or

(ii) ages four and above, SaO₂ level equal to or less than 90%.

(iii) Requests from the qualified medical practitioner for oxygen for children who do not meet these requirements should include documentation

of the medical necessity based on the child's clinical condition. These requests are considered on a case-by-case basis.

(b) Certificate of medical necessity.

(1) ~~The medical DMEPOS supplier must have a fully completed current CMN(CMS-484 or HCA-32 must be used for members 20 years of age and younger) on file to support the claims for oxygen or oxygen supplies, and to establish whether coverage criteria are met and to ensure that the oxygen services provided are consistent with the physician's prescription (refer to instructions from Palmetto Government Benefits Administration, the Oklahoma Medicare Carrier, for further requirements for completion of the CMN).~~

(2) ~~The CMN must be signed by the physician prior to submitting the initial claim. When a physician prescription for oxygen is renewed, a CMN, including the required retesting, must be completed by the physician prior to the submission of claims. The medical and prescription information on the CMN may be completed by a non-physician clinician, or an employee of the physician for the physician's review and signature. In situations where the physician has prescribed oxygen over the phone, it is acceptable to have a cover letter containing the same information as the CMN, stating the physician's orders, as long as the CMN has been signed by the physician or as set out above. The CMN must be signed by the qualified medical practitioner prior to submitting the initial claim. If a verbal order containing qualifying data is received by the DME provider, oxygen and supplies may be dispensed using the verbal order date as the billing date. The CMN initial date, the verbal order date, and the date of delivery should be the same date. It is acceptable to have a cover letter containing the same information as the CMN, stating the qualified medical practitioner's orders. The CMN signed by the qualified medical practitioner must be attached to the PAR.~~

(3) ~~Prescription for oxygen services must be updated at least annually and at any time a change in prescription occurs during the year. All DMEPOS suppliers are responsible for maintaining the prescription(s) for oxygen services and CMN in each member's file. If any change in prescription occurs, the physician must complete a new CMN that must be maintained in the member's file by the DME supplier. The OHCA or its designated agent will conduct on-going monitoring of prescriptions for oxygen services to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements. The medical and prescription information on the CMN may be completed by a non-physician clinician, or an employee, for the qualified medical practitioner's review and signature.~~

(4) When a Certificate of Medical Necessity for oxygen is recertified, a prior authorization request will be required.

(5) Re-certification and related retesting will be required every 12 months.

(6) CMN for oxygen services must be updated at least annually and at any time a change in prescription occurs during the year. All DMEPOS suppliers are responsible for maintaining the prescription(s) for oxygen services and CMN in each member's file.

(7) The OHCA or its designated agent will conduct on-going monitoring of prescriptions for oxygen services to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.

317:30-5-211.12. Oxygen rental

A monthly rental payment is made for rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators. The rental payment for a stationary system includes all contents and supplies, such as, regulators, tubing, masks, etc that are medically necessary. An additional monthly payment may be made for a portable liquid or gaseous oxygen system based on medical necessity.

(1) Oxygen concentrators are covered items for members residing in their home or in a nursing facility.

(2) For members who meet medical necessity criteria, SoonerCare covers portable liquid or gaseous oxygen systems. Portable oxygen contents are not covered for adults. The need for a portable oxygen system must be stated on the CMN. A portable system that is used as a backup system only is not a covered item.

(3) When ~~six~~four or more liters of oxygen are medically necessary, an additional payment will be paid up to 150% of the allowable for a stationary system when billed with the appropriate modifier.

[OAR Docket #14-703; filed 7-8-14]

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

[OAR Docket #14-702]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 79. Dentists

317:30-5-696. [AMENDED]

(Reference APA WF # 14-06)

AUTHORITY:

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

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SUPERSEDED EMERGENCY ACTIONS:

N/A

Emergency Adoptions

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's individual providers and specialties guidelines. These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

ANALYSIS:

Dental rules are revised to eliminate the perinatal dental benefit.

CONTACT PERSON:

Tywanda Cox at (405)522-7153

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR JULY 1, 2014, WHICHEVER IS LATER AS SET FORTH IN 75 O.S., SECTION 253(F):

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 79. DENTISTS

317:30-5-696. Coverage by category

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

(1) Adults.

(A) Dental coverage for adults is limited to:

- (i) emergency extractions;
- (ii) Smoking and Tobacco Use Cessation Counseling; and
- (iii) medical and surgical services performed by a dentist, to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, when those services would be covered if performed by a physician.

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

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

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

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under 21 years

of age without prior authorization. ALL OTHER DENTAL SERVICES MUST BE PRIOR AUTHORIZED. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** This procedure is performed for any member not seen by any dentist for more than 12 months.

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

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

(D) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include member history, prior radiographs, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Panoramic films are allowable once in a three year period and must be of diagnostic quality. Panoramic films are only compensable when chart documentation clearly indicates the test is being performed to rule out or evaluate non-caries related pathology. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through 18 years of age and is compensable only once per lifetime. Replacement of sealants is not a covered service under the SoonerCare program.

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

(G) **Composite restorations.**

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

- (I) tooth numbers O and P to age 4 years;
- (II) tooth numbers E and F to age 6 years;
- (III) tooth numbers N and Q to 5 years; and
- (IV) tooth numbers D and G to 6 years.

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

(iii) Class I and II composite restorations are allowed in posterior teeth; however, the OHCA has

- certain restrictions for the use of this restorative material. (See OAC 317:30-5-699).
- (H) **Amalgam.** Amalgam restorations are allowed in:
- (i) posterior primary teeth when:
 - (I) 50 percent or more root structure is remaining;
 - (II) the teeth have no mobility; or
 - (III) the procedure is provided more than 12 months prior to normal exfoliation.
 - (ii) any permanent tooth, determined as medically necessary by the treating dentist.
- (I) **Stainless steel crowns for primary teeth.** The use of any stainless steel crowns is allowed as follows:
- (i) Stainless steel crowns are allowed if:
 - (I) the child is five years of age or under;
 - (II) 70 percent or more of the root structure remains; or
 - (III) the procedure is provided more than 12 months prior to normal exfoliation.
 - (ii) Stainless steel crowns are treatment of choice for:
 - (I) primary teeth with pulpotomies or pulpectomies, if the above conditions exist;
 - (II) primary teeth where three surfaces of extensive decay exist; or
 - (III) primary teeth where cuspal occlusion is lost due to decay or accident.
 - (iii) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.
 - (iv) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other restorative procedure on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.
- (J) **Stainless steel crowns for permanent teeth.** The use of any stainless steel crowns is allowed as follows:
- (i) Stainless steel crowns are the treatment of choice for:
 - (I) posterior permanent teeth that have completed endodontic therapy if three or more surfaces of tooth is destroyed;
 - (II) posterior permanent teeth that have three or more surfaces of extensive decay; or
 - (III) where cuspal occlusion is lost due to decay prior to age 16 years.
 - (ii) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.
 - (iii) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other restorative procedure on that tooth is compensable during that period of time.

- A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.
- (K) **Pulpotomies and pulpectomies.**
- (i) Therapeutic pulpotomies are allowable for molars and teeth numbers listed below. Pre and post operative periapical x-rays must be available for review, if requested.
 - (I) Primary molars having at least 70 percent or more of their root structure remaining or more than 12 months prior to normal exfoliation;
 - (II) Tooth numbers O and P before age 5 years;
 - (III) Tooth numbers E and F before 6 years;
 - (IV) Tooth numbers N and Q before 5 years; and
 - (V) Tooth numbers D and G before 5 years.
 - (ii) Pulpectomies are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.
- (L) **Anterior root canals.** Payment is made for the services provided in accordance with the following:
- (i) This procedure is done for permanent teeth when there are no other missing anterior teeth in the same arch requiring replacement.
 - (ii) Acceptable ADA filling materials must be used.
 - (iii) Preauthorization is required if the member's treatment plan involves more than four anterior root canals.
 - (iv) Teeth with less than 50 percent of clinical crown should not be treatment-planned for root canal therapy.
 - (v) Pre and post operative periapical x-rays must be available for review.
 - (vi) Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA.
 - (vii) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for 24 month post completion.
 - (viii) Endodontic treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.
 - (ix) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.
- (M) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six months post insertion.
- (i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

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- (I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than 5mm below the crest of the alveolar ridge or where the successor tooth would not normally erupt in the next 12 months.
- (II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.
- (III) If there are missing teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.
- (IV) The teeth numbers shown on the claim should be those of the missing teeth.
- (V) Post operative bitewing x-rays must be available for review.
- (VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.
- (ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:
- (I) Lingual arch bar is used when permanent incisors are erupted and multiple missing teeth exist in the same arch.
- (II) The requirements are the same as for band and loop space maintainer.
- (III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age 6 years to prevent abnormal swallowing habits.
- (IV) Pre and post operative x-rays must be available.
- (iii) **Interim partial dentures.** This service is for anterior permanent tooth replacement or if the member is missing three or more posterior teeth to age 16 years.
- (N) **Analgesia.** Analgesia services are reimbursable in accordance with the following:
- (i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four occurrences per year and is not separately reimbursable, if provided on the same date by the same provider as IV sedation, non-intravenous conscious sedation or general anesthesia. The need for this service must be documented in the member's record. This procedure is not covered when it is the dentist's usual practice to offer it to all patients.
- (ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date by the same provider as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and /or the dentist, it must be medically necessary.
- (O) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted materials, not a cavity liner. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.
- (P) **Sedative restorations.** Sedative restorations include removal of decay, if present, and direct or indirect pulp cap, if needed. These services are reimbursable for the same tooth on the same date of service. Permanent restoration of the tooth is allowed after 30 days unless the tooth becomes symptomatic and requires pain relieving treatment.
- (Q) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.
- (R) **Local anesthesia.** This procedure is included in the fee for all services.
- (S) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.
- (T) **Periodontal scaling and root planing.** This procedure is designed for the removal of calculus or tissue that is contaminated and requires anesthesia and some soft tissue removal. This procedure requires that each tooth have 3 or more of the 6 point measurements 5 millimeters or greater, or have multiple areas of radiographic bone loss and subgingival calculus and must involve two or more teeth per quadrant

for consideration. This procedure is not allowed on members under age 10. This procedure is not allowed in conjunction with any other periodontal surgery.

(4) **Pregnant Women.** Dental coverage for this special population is provided regardless of age.

(A) Proof of pregnancy is required (Refer to OAC 317:35-5-6).

(B) Coverage is limited to a time period beginning at the diagnosis of pregnancy and ending upon 60 days post partum.

(C) In addition to dental services for adults, other services available include:

(i) Comprehensive oral evaluation must be performed and recorded for each new member, or established member not seen for more than 24 months;

(ii) Periodic oral evaluation as defined in OAC 317:30-5-696(3)(B);

(iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an oral examination by the same provider for the same member, or if the member is under active treatment;

(iv) Radiographs as defined in OAC 317:30-5-696(3)(D);

(v) Dental prophylaxis as defined in OAC 317:30-5-696(3)(F);

(vi) Composite restorations:

(I) Any permanent tooth that has an opened lesion seen on radiograph or that is a documented food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.

(II) Class I One and two surface posterior composite resin restorations are allowed in posterior teeth that qualify;

(vii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and

(viii) Analgesia. Analgesia services are reimbursable in accordance with OAC 317:30-5-696(3)(N).

(D) Services requiring prior authorization (Refer to OAC 317:30-5-698).

(E) Periodontal scaling and root. Procedure is designed for the removal of calculus or tissue that is contaminated and requires anesthesia and some soft tissue removal. This procedure requires that each tooth have 30 or more of the 6 point measurements 5 millimeters or greater, or have multiple areas of radiographic bone loss and subgingival calculus and must involve two or more teeth per quadrant for consideration. This procedure is not allowed on members under age 10. This procedure is not allowed in conjunction with any other periodontal surgery.

(54) **Individuals eligible for Part B of Medicare.**

(A) Payment is made based on the member's coinsurance and deductibles.

(B) Services which have been denied by Medicare as non-compensable should be filed directly with the OHCA with a copy of the Medicare EOB indicating the reason for denial.

[OAR Docket #14-702; filed 7-8-14]

**TITLE 777. STATEWIDE VIRTUAL
CHARTER SCHOOL BOARD
CHAPTER 10. STATEWIDE VIRTUAL
CHARTER SCHOOLS**

[OAR Docket #14-665]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 1. General Provisions [NEW]

777:10-1-2. Definitions [NEW]

AUTHORITY:

70 O.S. §§ 3-130 through 3-145.6; Statewide Virtual Charter School Board.

ADOPTION:

May 13, 2014

APPROVED BY GOVERNOR:

July 1, 2014

EFFECTIVE:

Immediately upon Governor's approval

EXPIRATION:

Effective through September 14, 2015, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The proposed new rule is necessary as an emergency measure pursuant to the provisions of 75 O.S. § 253(A)(1)(a) and (e).

The Oklahoma Charter Schools Act establishes a clear distinction between charter schools established as "brick and mortar" charter schools to provide traditional face-to-face instruction to students and statewide virtual charter schools established to provide full-time virtual education to students. For example, one of the primary distinctions between these two types of charter schools in the Act is that traditional "brick and mortar" charter schools may only apply to the entities set forth in 70 O.S. § 3-132 for sponsorship of a charter school; their charter school sites are limited to certain geographical boundaries set forth in 70 O.S. § 3-134; and pursuant to 70 O.S. § 3-140, they are subject to limitations on enrollment of students who do not reside within a school district sponsoring the charter school. By contrast, providers of full-time virtual education may apply for sponsorship with the Statewide Virtual Charter School Board, thereby allowing the provider to operate as a statewide virtual charter school, which in turn allows the school to offer enrollment to students who live within the geographical boundaries of the entire State of Oklahoma.

70 O.S. § 3-145.5 prohibits school districts from offering and/or providing full-time virtual education to non-resident students. The statute also includes a provision, which becomes effective July 1, 2014, that directs the Statewide Virtual Charter School Board to succeed "to any contractual rights and responsibilities incurred by a school district in a virtual charter school contract executed prior to January 1, 2014, with a provider to provide full-time virtual education to students who do not reside within the school district boundaries." Consequently, the definitions in the proposed rules are necessary to clearly distinguish which providers fall within the purview of the statute as an existing full-time virtual provider with a charter school contract for sponsorship to be assumed by the Board.

In addition, the proposed emergency rule is necessary to avoid serious prejudice to the public interest resulting from full-time virtual education providers that attempt to circumvent the limitations on authorization and operation applicable to traditional "brick and mortar" charter schools by organizing as a statewide virtual charter schools, but providing face-to-face instruction to students in a manner that is inconsistent with the Act's intent.

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ANALYSIS:

The purpose of the proposed emergency rule is to define terms used in the proposed emergency rule pertaining to the statewide virtual charter school facilities and face-to-face instruction at charter school sites at 777:10-5-3. The proposed new rule also defines and clarifies what constitutes a statewide virtual charter school subject to the regulation and oversight of the Statewide Virtual Charter School Board and its rules at Title 777 of the Oklahoma Administrative Code.

CONTACT PERSON:

Stephanie Moser Goins, (405) 521-4890

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

SUBCHAPTER 1. GENERAL PROVISIONS

777:10-1-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning:

"Charter school site" or "school site" or "statewide virtual charter school site" means the physical location of any facility or structure, other than the legal residence of a student or the parent/legal guardian of a student, approved by the Statewide Virtual Charter School Board for use by a statewide virtual charter school to provide face-to-face or virtual instruction to students enrolled in the statewide virtual charter school.

"Face-to-face instruction" means any in-person tutoring, educational instruction, or any other activity provided by the statewide virtual charter school to an enrolled student for which the student's physical presence and/or participation is used by the charter school to earn credit for a virtual course, meet the instructional requirements of 70 O.S. § 1-111 and/or counted toward the student's compulsory attendance requirements set forth at Art. 13, § 4 of the Oklahoma Constitution, 70 O.S. § 10-105, and/or accompanying regulations of the State Department of Education relating to student attendance.

"Statewide virtual charter school" means any charter school sponsored by the Statewide Virtual Charter School Board in accordance with the requirements of the Oklahoma Charter Schools Act for the purpose of providing full-time virtual public school courses of instruction for Pre-K through twelfth (12th) grade students whose legal residence is located within the State of Oklahoma.

[OAR Docket #14-665; filed 7-7-14]

TITLE 777. STATEWIDE VIRTUAL CHARTER SCHOOL BOARD CHAPTER 10. STATEWIDE VIRTUAL CHARTER SCHOOLS

[OAR Docket #14-666]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 3. Statewide Virtual Charter School Sponsorship [NEW]

777:10-3-5. Full-time virtual charter schools - succession of contractual rights and reversion of property to Statewide Virtual Charter School Board [NEW]

AUTHORITY:

70 O.S. §§ 3-135; 3-136; 3-145.4; 3-145.5; Statewide Virtual Charter School Board

ADOPTION:

May 13, 2014

APPROVED BY GOVERNOR:

July 1, 2014

EFFECTIVE:

Immediately upon Governor's approval

EXPIRATION:

Effective through September 14, 2015, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The proposed new rule is necessary as an emergency measure pursuant to the provisions of 75 O.S. § 253(A)(1)(c) and (e).

70 O.S. § 3-145.5(B) directs the Statewide Virtual Charter School Board to "succeed to any contractual rights and responsibilities incurred by a school district in a virtual charter school contract executed prior to January 1, 2014, with a provider to provide full-time virtual education to students who do not reside within the school district boundaries. All property, equipment, supplies, records, assets, current and future liability, encumbrances, obligations and indebtedness associated with the contract shall be transferred to the Statewide Virtual Charter School Board. Appropriate conveyances and other documents shall be executed to effectuate the transfer of any property associated with the contract. Upon succession of the contract, the Board shall assume sponsorship of the virtual charter school for the remainder of the term of the contract." However, as of the date of adoption of the emergency rule, the Statewide Virtual Charter School Board has not been provided with the documentation from the full-time virtual providers necessary to comply with the requirements of the statute, which becomes effective July 1, 2014. The proposed emergency rule is also necessary to avoid violation of 70 O.S. § 3-145.5(B) by establishing a procedure for compliance and requiring delivery of all documentation necessary for the Statewide Virtual Charter School Board to determine what assets and liabilities are to be transferred to the Board. The proposed emergency rule is also necessary to avoid serious prejudice to the public interest by ensuring a procedure is in place to ensure orderly reversion of property in accordance with the provisions of 70 O.S. § 3-136(F) in the event of closure of an existing statewide virtual charter school.

ANALYSIS:

The proposed emergency rule establishes procedures for reversion of charter school property to the Statewide Virtual Charter School Board in accordance with the requirements of 70 O.S. § 3-136(F). The proposed rule also establishes procedures for assumption of the two existing contracts for sponsorship of statewide virtual charter schools by the Statewide Virtual Charter School Board in accordance with the requirements of 70 O.S. § 3-145.5.

CONTACT PERSON:

Stephanie Moser Goins, (405) 521-4890

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

SUBCHAPTER 3. STATEWIDE VIRTUAL CHARTER SCHOOL SPONSORSHIP

777:10-3-5. Full-time virtual charter schools - succession of contractual rights and reversion of property to Statewide Virtual Charter School Board

(a) Reversion of real and personal property to Statewide Virtual Charter School Board. Pursuant to 70 O.S. § 3-136(F), upon the date of expiration or termination of a contract for sponsorship for a statewide virtual charter school, or in the event of a failure of a statewide virtual charter school to continue operations, all real and personal property acquired by the charter school shall be disposed of as set forth in the contract for sponsorship and in accordance with the following provisions:

(1) All unencumbered state aid, local, or federal funds, and all real property and personal property for which state, local or federal funds have been used all or in part to procure the property, shall be retained by the Statewide Virtual Charter School Board as the sponsor.

(2) All funds and property subject to the provisions of this subsection shall be deemed to revert to the Board as of the Termination Date. For purposes of this Section the Termination Date shall be either:

(A) The effective date of expiration or termination of the contract for sponsorship; or

(B) In the event a statewide virtual charter school fails to continue operation prior to expiration or termination of the contract, the date upon which the last day of courses were provided to students enrolled in the charter school.

(3) No later than ninety (90) calendar days prior to the date of expiration of the sponsorship contract, the statewide virtual charter school shall provide the Secretary of the Statewide Virtual Charter School Board with executed copies of all of the following documents:

(A) A detailed list of all real and/or personal property and other assets procured by the charter school during the term of the contract that includes identification of all sources of funds used to procure the property. All items procured all or in part with state, local or federal funds shall be clearly identified;

(B) Title documents, deeds, and/or leases for all real or personal property or other assets procured all or in part with state or federal funds;

(C) Copies of all executory contracts to which the charter school or its governing body is a party; and

(D) All documentation relating to debt, liabilities, encumbrances, or other obligations incurred by the charter school and/or the governing body of the charter school during the term of the sponsorship contract.

(4) The Statewide Virtual Charter School Board shall have forty-five (45) days after the date of delivery of all of the documents set forth in (3) of this subsection to request any additional documentation from the charter school the Board deems necessary to determine the assets and liabilities of the statewide virtual charter school.

(5) No later than forty-five (45) days after the Termination Date, the charter school shall complete and provide the Statewide Virtual Charter School Board with a final

audit of the charter school that complies with the annual audit requirements of the Oklahoma Public School Audit Law at 70 O.S. § 22-101 et seq and accompanying regulations.

(6) No later than sixty (60) calendar days after the Termination Date, the charter school shall deliver all records pertaining to operation of the charter school and its students to the Secretary of the Statewide Virtual Charter School Board or to the State Department of Education.

(7) All personal property of the charter school reverting to the Statewide Virtual Charter School Board in accordance with the provisions of 70 O.S. 3-136 and this Section shall be delivered to the Secretary of the Board no later than sixty (60) calendar days after the Termination Date in the manner and to the location(s) directed by the Board.

(8) The Chairman of the Statewide Virtual Charter School Board is authorized to execute conveyances and documents on behalf of the Board as necessary to fulfill the requirements of this subsection.

(b) School district contracts for sponsorship of full-time virtual charter schools. In accordance with the provisions of 70 O.S. 3-145.5, the following provisions shall apply to school district contracts for sponsorship of charter schools who provide full-time virtual education:

(1) **Contracts for sponsorship of a full-time virtual charter school.** Beginning July 1, 2014, no school district shall:

(A) Offer full-time virtual education to any student whose legal residence, as determined in accordance with the provisions of 70 O.S. § 1-113, is located outside of the boundaries of the school district; or

(B) Enter a contract to provide full-time virtual education to any student whose legal residence, as determined in accordance with the provisions of 70 O.S. § 1-113, is located outside of the boundaries of the school district.

(2) **Succession of contracts for school district sponsorship of a virtual charter school executed prior to January 1, 2014.** Beginning July 1, 2014, the Statewide Virtual Charter School Board shall succeed to the contractual sponsorship rights of any school district that executed a contract for sponsorship of a charter school prior to January 1, 2014. Contract succession shall be conducted in accordance with all of the following procedures:

(A) No later than July 1, 2014, the charter school shall provide the Secretary of the Statewide Virtual Charter School Board with all of the following documents:

(i) All of the documentation set forth in (a)(3) through (a)(4) of this Section; and

(ii) Copies of all reports, documents, and statements required by the Oklahoma Public School Audit Law, for all previous fiscal years of the charter school's operation; including, but not limited to, auditor's opinions and related financial statements of the charter school; and

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- (iii) Copies of the charter school's annual estimate of needs, and income and expenditure data required by 70 O.S. §§ 5-135 and 5-135.2 for all previous fiscal years of the charter school's operation.
- (B) The terms of succession to the contract for sponsorship by the Statewide Virtual Charter School Board shall be as follows:
- (i) The Statewide Virtual Charter School Board shall not succeed to any terms of a contract for sponsorship executed between a charter school and a school district that violates or conflicts with the Oklahoma Charter Schools Act and/or any state or federal laws and regulations applicable to charter schools, charter school sponsors, or the Statewide Virtual Charter School Board. In the event that any such statute or regulation goes into effect during the term of the contract, the conflicting contractual term shall be deemed superceded by law and deemed null and void.
- (ii) Any debt, obligations, encumbrances, and/or liabilities incurred by the charter school in violation of the provisions of Art. 10 § 26 of the Oklahoma Constitution shall be deemed null and void, and shall not be assumed by the Statewide Virtual Charter School Board.
- (iii) The Statewide Virtual Charter School Board may require the statewide virtual charter school to execute an addendum to the contract for sponsorship for the purpose of clarifying terms not otherwise addressed in the existing contract as necessary to comply with the Oklahoma Charter Schools Act or any other provision of state or federal law applicable to charter schools.
- (C) The Statewide Virtual Charter School Board shall not distribute any state aid funds to a statewide virtual charter school pursuant to the provisions of this subsection until all of the following conditions have been met:
- (i) All appropriate conveyances and other documents necessary to effect the transfer of any property associated with the contract have been finally executed by the parties and copies of the finally executed documents have been filed with the Secretary of the Statewide Virtual Charter School Board;
- (ii) All property, equipment, supplies, records, and assets required to be transferred to the Statewide Virtual Charter School Board in accordance with the provisions of 70 O.S. § 3-145.5(B) has been delivered in the manner and to the location(s) directed by the Board;
- (iii) The charter school is in compliance with all applicable state and federal regulations pertaining to charter schools; and
- (iv) All other requirements of this paragraph have been met.

(D) The Statewide Virtual Charter School Board shall not distribute midyear allocation funds to a statewide virtual charter school that is a party to a contract for sponsorship assumed by the Statewide Virtual Charter School pursuant to the provisions of this subsection until:

(i) The statewide virtual charter school has conducted a final audit of the charter school for fiscal year 2014 that complies with the Oklahoma Public School Audit Law at 70 O.S. § 22-101 et seq and accompanying regulations;

(ii) Copies of the auditor's opinions, related financial statements, and any other documentation pertaining to the audit have been provided to the Statewide Virtual Charter School Board; and

(iii) The charter school has presented the audit at a meeting of the Statewide Virtual Charter School Board.

(E) Succession to the contractual rights and responsibilities of sponsorship by the Statewide Virtual Charter School Board shall not qualify the charter school to apply for funds from the Charter School Incentive Fund established pursuant to the provisions of 70 O.S. § 3-144, nor shall the first year of operation under the sponsorship of the Board be considered the charter school's first year of operation.

(F) The Chairman of the Statewide Virtual Charter School Board is authorized to execute conveyances and documents on behalf of the Board as necessary to fulfill the requirements of this subsection.

(c) **Termination or nonrenewal for good cause.** Failure by any charter school to comply with the provisions of this Section shall constitute good cause for:

(1) Termination or nonrenewal of a contract for sponsorship with the Statewide Virtual Charter School Board; and/or

(2) Denial of any application for sponsorship subsequently submitted by the charter school and/or authorized representatives of the charter school, including, but not limited to, the governing body of a charter school.

[OAR Docket #14-666; filed 7-7-14]

TITLE 777. STATEWIDE VIRTUAL CHARTER SCHOOL BOARD CHAPTER 10. STATEWIDE VIRTUAL CHARTER SCHOOLS

[OAR Docket #14-667]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Statewide Virtual Charter School Sites [NEW]
777:10-5-3. Statewide virtual charter school sites [NEW]

AUTHORITY:

70 O.S. §§ 3-130 through 3-145.6; Statewide Virtual Charter School Board

ADOPTION:

May 13, 2014

APPROVED BY GOVERNOR:

July 1, 2014

EFFECTIVE:

Immediately upon Governor's approval

EXPIRATION:

Effective through September 14, 2015, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The proposed new rule is necessary as an emergency measure pursuant to the provisions of 75 O.S. § 253(A)(1)(a) and (e).

The proposed emergency rule is necessary to protect the public health, safety, and welfare of students enrolled in statewide virtual charter schools and teachers and other school staff employed by statewide virtual charter schools. Without the emergency rule, students enrolled in statewide virtual charter schools may be required or encouraged by the school or its employees to receive in-person instruction in unsafe facilities, outside of the student's home, that do not comply with the health and safety regulations to which all other charter school and public school facilities are subject. For example, without the proposed emergency rule, a statewide virtual charter school could encourage or require students enrolled as full-time virtual charter school students to meet at facilities that lack adequate emergency exits; safe systems for plumbing and ventilation; disability accommodations; limitations on maximum occupancy; and systems to protect students from access by unauthorized individuals and/or intruders.

In addition, the proposed emergency rule is necessary to avoid serious prejudice to the public interest resulting from full-time virtual education providers that attempt to circumvent the limitations on authorization and operation applicable to traditional "brick and mortar" charter schools by organizing as a statewide virtual charter school, but providing face-to-face instruction to students in a manner that is inconsistent with the Act's intent.

ANALYSIS:

The proposed emergency rule requires that any facilities used by a statewide virtual charter school to provide face-to-face instruction to enrolled students must comply with all applicable statutes and regulations governing health and safety of public school facilities and that the facilities be approved in advance by the Statewide Virtual Charter School Board for use by the virtual charter school. The proposed emergency rule also establishes limits on the amount of face-to-face instruction a full-time virtual provider may offer a student enrolled as a full-time virtual charter school student of the virtual charter school. Further, the proposed rule also requires statewide virtual charter schools to report approved statewide virtual charter school sites to the State Department of Education. In addition, the proposed rule requires submission of an approved transportation plan as a prerequisite for any statewide virtual charter school to make a claim for any transportation supplement funding pursuant to 70 O.S. § 3-141.

CONTACT PERSON:

Stephanie Moser Goins, (405) 521-4890

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

777:10-5-3. Statewide virtual charter school sites

(a) Face-to-face instruction. No statewide virtual charter school or employee of the statewide virtual charter school shall provide face-to-face instruction to any charter school student unless:

- (1) The instruction occurs at either:**
 - (A) The legal residence of a student or the parent/legal guardian of a student; or**
 - (B) A facility approved as a charter school site of the statewide virtual charter school in which the student is enrolled; and**

(2) The instruction is limited to no more than three (3) days per week of up to three (3) hours of instruction per student on each of those three (3) days.

(b) Approval of statewide virtual charter school sites. The Board may approve a charter school site if the following conditions have been met:

- (1) The statewide virtual charter school submits an application at least sixty (60) days prior to beginning face-to-face instruction at the facility;**
- (2) The facility complies with all federal and state statutes and regulations governing safety that are applicable to public school facilities; and**
- (3) The facility has been approved by the State Department of Education Office of Accreditation.**

(c) Reporting of approved statewide virtual charter school sites. No later than July 1 prior to each school year, each statewide virtual charter school shall provide the State Department of Education with a list of all approved statewide virtual charter school sites. A statewide virtual charter school shall not be eligible to obtain funding for instruction provided at any statewide virtual charter school site not approved and reported in accordance with the provisions of this Section and all other applicable statutes and regulations pertaining to charter school facilities.

(d) Transportation supplement funding. A statewide virtual charter school shall not be eligible to receive transportation supplement funding for transportation to a statewide virtual charter school site in accordance with the provisions of 70 O.S. § 3-141 for any school year without a written transportation plan approved by the Statewide Virtual Charter School Board. The statewide virtual charter school shall submit its approved transportation plan to the State Department of Education Office of State Aid no later than July 1 prior to the school year for which the transportation plan has been approved.

[OAR Docket #14-667; filed 7-7-14]

SUBCHAPTER 5. STATEWIDE VIRTUAL CHARTER SCHOOL FACILITIES

