
POLICY TRANSMITTAL NO. 07-02	DATE: MARCH 7, 2007
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS & POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-3-57; 30-5-8; 30-5-96.2; 30-5-134; 30-5-180 through 30-5-180.5; 30-5-211; and 35-5-41

EXPLANATION: **Policy revisions were approved by the Board and the Governor as required by the Administrative Procedures Act.**

SoonerCare coverage rules and rules for medical suppliers are revised to add external breast prosthesis and support garments as benefits to women who have had a mastectomy.

Surgery rules are revised to allow OHCA to comply with current protocol for required documentation of medical necessity for prior authorization of reduction mammoplasty.

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

Resource eligibility rules for individuals related to aged, blind and disabled are revised to increase the maximum monthly income for a Medicaid Income Pension Trust, also known as a Miller Trust, from \$2,500 to \$3,000.

Rules are revised to reflect transportation of family members to participate in family counseling with SoonerCare member who resides in a psychiatric residential treatment center is the responsibility of the facility. OHCA recently increased the per diem rate to facilities to cover this expense.

Long term care facility rules are revised to allow OHCA to make payments to nursing facilities for nurse aide training as an administrative claim instead of including the cost of nurse aide training in the nursing facility rate.

Original signed on 3-5-07

Mary Stalnaker, Director
Family Support Services Division

Sharon Neuwald, Coordinator
Office of Legislative Relations and Policy

WF # 07-C (NAP)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following an "OKDHS" number, such as personnel policy at OKDHS:2-1 and personnel rules at OAC 340:2-1. The "340" is the Title number that designates OKDHS as the rulemaking agency; the "2" specifies the Chapter number; and the "1" specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, OKDHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, OKDHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at 405-521-4326.

<u>REMOVE</u>	<u>INSERT</u>
317:30-3-57	317:30-3-57, pages 1-7, revised 2-1-07
317:30-5-8	317:30-5-8, pages 1-10, revised 2-1-07
317:30-5-96.2	317:30-5-96.2, pages 1-3, revised 2-1-07
317:30-5-134	317:30-5-134, pages 1-3, revised 2-1-07
-----	317:30-5-180, 1 page only, issued 2-1-07
-----	317:30-5-180.1, 1 page only, issued 2-1-07
-----	317:30-5-180.2, 1 page only, issued 2-1-07
-----	317:30-5-180.3, 1 page only, issued 2-1-07
-----	317:30-5-180.4, 1 page only, issued 2-1-07
-----	317:30-5-180.5, 1 page only, issued 2-1-07
317:30-5-211	317:30-5-211, pages 1-8, revised 2-1-07
317:35-5-41	317:35-5-41, pages 1-34, revised 2-1-07

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

The following are general SoonerCare coverages 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.

(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) Family planning centers.

(16) Physicians' services whether furnished in the office, the member's home, a hospital, a nursing facility, ICF/MR, or elsewhere. For adults, payment is made for up to the limited number of compensable hospital days described at OAC 317:30-5-41. These days will be maintained on the recipient record. Physician claims for hospital visits will be paid until the last compensable hospital day is captured. After the limited number of hospital days have been captured, inpatient physician services will not be paid beyond the last compensable hospital day. Office visits for adults are limited to four per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

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

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

(18) Free-standing ambulatory surgery centers.

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

- (A) unlimited medically necessary monthly prescriptions for:
 - (i) members under the age of 21 years; and
 - (ii) residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded.

(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 three brand name or thirteen total prescriptions are covered with prior authorization.

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

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

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

age 21.

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

(24) Standard medical supplies.

(25) Eyeglasses under EPSDT for members under age 21. Payment is also made for glasses for children with congenital aphakia or following cataract removal.

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

(27) 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.

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

(29) 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.

(30) 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.

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

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

(33) 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.

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

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

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

(37) 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.

(38) Home and community-based waiver services for mentally retarded members who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).

(39) Case Management services for the chronically and/or severely mentally ill.

(40) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.

(41) Services delivered in Federally Qualified Health Centers.

Payment is made on an encounter basis.

(42) Early Intervention services for children ages 0-3.

(43) Residential Behavior Management in therapeutic foster care setting.

(44) Birthing center services.

(45) Case management services through the Oklahoma Department of Mental Health and Substance Abuse.

(46) Home and Community-Based Waiver services for aged or physically disabled members.

(47) Outpatient ambulatory services for members infected with tuberculosis.

(48) Smoking and Tobacco Use Cessation Counseling for children and adults.

(49) Services delivered to American Indians/Alaskan Natives in I/T/Us. Payment is made on an encounter basis.

317:30-5-8. Surgery

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

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

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

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

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

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

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

result in very different payments.

(A) Bilateral Procedure. This modifier is to be used when there is no specific code in the CPT for a bilateral procedure. List the bilateral procedure on one line followed by modifier -50. The payment will be 150 percent of the base allowable for the procedure so it is no longer necessary to list the procedure twice on a claim when it is bilateral. The units of service are shown as "1".

(B) Multiple surgery. When a surgeon or assistant surgeon performs multiple surgery, modifier -51 is applied to the secondary procedures. The multiple surgery rule provides that the second and subsequent surgeries are paid at a lesser amount. The major procedure is listed without a -51 modifier. This procedure will be whole or full allowable. All other procedures done at the same session are identified by modifier -51. If the secondary procedure(s) require modifier -51 and modifier -51 is not used, the claim will be denied with the message, "756 - must add modifier to CPT/HCPC." Modifier -51 prices the claim at fifty percent of the allowable.

(6) -52 Reduced services - This modifier will be handled like modifier -51. The claim will be paid at 50 percent of the allowable.

(7) -54 Surgical care only - This is applied to the procedure code when the physician performs itinerant surgery or another physician provides the post-operative care. OHCA will pay this at eighty percent of the allowable for the full procedure.

(8) -55 Postoperative management only - When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component is identified by adding the modifier -55 to the usual procedure number. When the surgery is performed by an "itinerant surgeon", and postoperative care is provided by another physician, payment is made for postoperative care under modifier -55 at the rate of 20% of the surgical allowable. When the surgery is cataract surgery performed by an ophthalmologist as an "itinerant surgeon", the postoperative care is paid to the optometrist providing the postoperative care under modifier -55. Payment in this instance will also be made at 20% of the surgical allowable.

(9) -56 Preoperative management only - OHCA will deny payment for this modifier. The physician who provides the preoperative care files under the appropriate medicine codes. A preoperative exam is considered part of the global fee for surgery.

(10) -62 Two surgeons - This modifier is used when two surgeons work as co-surgeons. The code is used when the skills of two surgeons (usually of different specialties) are required in the management of a specific surgical procedure. OHCA will pay this at sixty percent of the allowable for the full procedure. The claims from both surgeons must reflect this modifier.

(11) -66 Surgical team - OHCA will deny payment for this modifier. Each physician must file individually using appropriate modifiers.

(12) -75 Concurrent care - This modifier is used when the member requires the services of two or more physicians. All claims for payment of concurrent care are suspended for medical review. This -75 modifier shows that a specialist is seeing the patient in consultation and rendering a special service or procedure in addition to the services of the admitting physician or primary physician.

(13) -76 Repeat procedure by same physician - This is not to be used for bilateral surgery. When the same physician performs the same procedure two or more times on the same day, the claim is billed showing the procedure code and the number of times it was performed on one line unless the code itself signifies that multiple services were provided. This is particularly important for radiologists, as repeat procedures on the same day may otherwise deny as duplicates. However, if a repeat procedure on same day was omitted on the first filing, a claim is filed with modifier -76. If the claim is for professional component, modifier -26 must be entered as the first modifier and -76 as the second modifier. Alternately, the physician files an adjusted claim showing the correct number of procedures.

(14) -77 Repeat procedure by another physician - This is not to be used for bilateral surgery. This modifier is used when appropriate as it identifies that the claim is not a duplicate of another physician's services. This is especially important for radiologists. If the claim is for professional component, modifier -26 is entered as the first modifier and -77 as the

second modifier.

(15) -78 Return to the operating room for a related procedure during the postoperative period - A procedure with this modifier suspends for physician review to determine appropriate payment.

(16) -79 Unrelated procedure or service by the same physician during the postoperative period - A procedure with this modifier suspends for physician review to determine appropriate payment.

(17) -80 Assistant surgeon:

(A) The assistant surgeon identifies his service by the use of modifier -80 or -82 as appropriate. This modifier is applied to each and every surgical procedure code listed on his claim.

(B) Where there is multiple surgery, the major procedure is followed by -80 and all secondary procedures will have two modifiers: -51, -80. These will follow the procedure code and be on the same line. OHCA will pay modifier -80 at twenty percent of the allowable for the full procedure. All secondary procedures require two modifiers, -51 and -80, and pay ten percent of the allowable for full procedure.

(18) -81 Minimum assistant surgeon - OHCA will deny payment for this modifier.

(19) -82 Assistant surgeon (when qualified resident surgeon not available) - This modifier is used when the claiming physician is the assistant surgeon in a teaching hospital; otherwise, the claim will be denied. OHCA will recognize modifier -82 and pay the modifier at twenty percent of the allowable for the procedure. See modifier -80 for multiple surgery.

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

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

(c) **Bilateral surgery.** When a bilateral procedure is performed,

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

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

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

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

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

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

(A) Some surgeries are never paid under the multiple surgery rule. In other words, they are never compensable when done

in conjunction with other surgeries; payment is made only for the major procedure. Examples are exploratory laparotomy, lysis of adhesions or appendectomy for staging done in conjunction with other abdominal surgery. These procedures are always incidental to the major procedure.

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

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

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

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

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

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

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

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

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

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

- (1) Appendectomy with hysterectomy.
- (2) Exploratory laparotomy with any abdominal or pelvic surgical procedures.
- (3) Ovarian cystectomy with hysterectomy or other ovarian surgery such as wedge-resection of ovaries.
- (4) Diagnostic arthroscopy of the knee with any other arthroscopic surgery of the knee.
- (5) Diagnostic laryngoscopy with any bronchoscopy procedure.
- (6) Only one laparoscopic procedure allowed.
- (7) Umbilica hernia repair when done at the same time as a ventral hernia repair.

(g) **Assistant surgeons.** If two surgeons claim as co-surgeons rather than as a primary and assistant surgeon, both use modifier - 62 (Two Surgeons) on their claims.

(1) The Authority will not make payment for two assistant surgeons.

(2) Federal rules provide that SoonerCare must not make payment

for an assistant surgeon in a teaching setting when a resident is available to provide the service. An assistant surgeon who claims for services provided in a teaching setting uses modifier -82 to identify that a resident was not available. These claims are subject to audit and review of the records. If a physician claims for assistant surgeon when a qualified resident was available, penalties may be levied.

(3) Many procedures do not require an assistant surgeon. OHCA will not pay for an assistant surgeon or co-surgeon when unnecessary.

(h) **Non-compensable surgery.** Procedures which are cosmetic are not covered for adults. Intra-dermal introduction of pigments or tattooing is considered cosmetic surgery and non-compensable for adults except when related to breast reconstruction after surgery for breast cancer and considered medically necessary. Intra-dermal introduction of pigments or tattooing require medical review prior to payment for children.

(i) **General surgery information.**

(1) When a D & C is performed in conjunction with abdominal hysterectomy, the full allowable is paid for the hysterectomy and 50% of the allowable is paid for the D & C (51 modifier required).

(2) When a D & C is performed in conjunction with a vaginal hysterectomy, only the hysterectomy can be paid.

(3) When multiple surgery involves tubal ligation, removal of tubes and ovaries, or other procedures for which specific codes exist, the regular procedure code is to be used. The proper consent form must also accompany these claims. If the multiple surgery **on a member under** 21 years of age involves tubal ligation; removal of the tubes and ovaries, or other procedures for which specific codes exist, the sterilization procedure is not compensable. No consent form is necessary since sterilization may not be paid for member under 21 years of age. A postpartum tubal ligation (Procedure Code 58605) is paid at one hundred percent of the allowable charge if the member is over 21 years of age and the claim is accompanied by an acceptable consent form.

(4) Vasectomy requires sterilization consent form. Considered incidental in conjunction with any urological operative

procedure.

(5) A cochlear implant device is not covered for members between the ages of 21 and 65. Cochlear implant is covered for members between the ages of two through 17 who meet all of the guidelines listed below.

(A) No contraindications to the implant, including those described in the product's FDA-approved package insert.

(B) Diagnosis of bilateral profound sensorineural deafness with little or no benefit from a hearing (or vibrotactile) aid, as demonstrated by the inability to improve on age appropriate closed-set word identification tasks.

(C) Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system.

(D) The device must be used in accordance with the FDA approved labeling.

(E) Claims are suspended for medical review to determine if the guidelines are met.

(6) All aspects of Electrophysiologic Study of the heart are done at one session (sinus node, A-V node, Bundle of HIS and arrhythmia itself). If more than one area is done at the same session, multiple surgery rules apply.

(7) Additional payment is allowed for use of marlex mesh or graft. Use code 99070.

(8) Gravlee jet washer - procedure is compensable only when the patient exhibits clinical symptoms suggestive of endometrial disease, such as irregular or heavy bleeding.

(9) A separate payment is not made for pre and post operative care billed in conjunction with surgery. This does not apply to those specific surgical procedures where the fee is considered to be for the surgical procedure only or to the initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. Payment for the pre-operative visit, on the date immediately prior to or on the date of the

procedure, either in the hospital, or elsewhere to examine the patient, complete the hospital records and initiate the treatment program, is included in the listed value for the surgery. All surgical procedures are considered to include typical, uncomplicated follow-up care unless otherwise indicated.

(10) Additional payment is not allowed for suprapubic cystotomy performed in conjunction with abdominal bladder or urethral surgery (Marshall-Marchetti). When suprapubic cystotomy is performed in conjunction with genito-urinary surgery from the vaginal approach, it would be allowed as multiple surgery.

(11) Balloon valvuloplasty of heart valves other than pulmonic valve, is not covered.

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

(13) Reduction mammoplasty is covered only when the procedure has been determined medically necessary; prior authorization is required.

**MEDICAL PROVIDERS-FEE FOR SERVICE
INPATIENT PSYCHIATRIC HOSPITALS SPECIFIC OAC 317:30-5-96.2 (p1)**

317:30-5-96.2. Payments definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

- (A) room and board;
- (B) treatment program components;
- (C) psychiatric treatment;
- (D) professional consultation;
- (E) medical management;
- (F) crisis intervention;
- (G) transportation;
- (H) rehabilitative services;
- (I) case management;
- (J) interpreter services (if applicable);
- (K) routine health care for individuals in good physical health; and
- (L) laboratory services for a substance abuse/detoxification program.

"Specialty treatment program/specialty unit" means acute or

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

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

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

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

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

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

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

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

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

(1) the training and competency evaluation program must be certified at the time the training occurred;

(2) the nurse aide has paid for training;

(3) a reasonable fee was paid for training (however, reimbursement will not exceed the maximum amount set by the Oklahoma Health Care Authority);

(4) the Oklahoma Health Care Authority is billed by the nurse aide receiving the training within 12 months of the completion of the training;

(5) the nurse aide has passed her or his competency evaluation;
and

(6) the nurse aide is employed at a SoonerCare contracted nursing facility as a nurse aide during all or part of the year

after completion of the training and competency evaluation.

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

(1) For every month employed in a nursing facility, OHCA will pay 1/12 of the sum of eligible expenses incurred by the nurse aide. The term "every month" is defined as a period of 16 days or more within one month.

(2) The maximum amount paid by the Oklahoma Health Care Authority may be set by the Rates and Standards Committee. The rate paid by the nurse aide, up to the maximum set by the Oklahoma Health Care Authority, will be paid in the event a nurse aide was employed all 12 months after completion of the training program.

(e) The claimant must submit a completed Nurse Aide Training Reimbursement Program Form and ADM-12 claim voucher. Documentation of eligible expenses must also be provided. Eligible expenses include course training fees, textbooks and exam fees.

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

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

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

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

rate, whichever is less.

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

**MEDICAL PROVIDERS-FEE FOR SERVICE
THE OKLAHOMA PRESCRIPTION DRUG
DISCOUNT PROGRAM**

OAC 317:30-5-180

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

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

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OAC 317:30-5-180.1

317:30-5-180.1. Definitions

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

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

"Network" means a group of individual retail pharmacies that contract with the designated Pharmacy Benefit Manager to participate in the OPDDP and honor the discount offered through this program.

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

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

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

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

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OAC 317:30-5-180.2

317:30-5-180.2. Eligibility

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

(1) be an Oklahoma resident;

(2) apply with the Pharmacy Benefit Manager (PBM);

(3) not have insurance to cover all or part of prescriptions;

(4) pay an enrollment fee when income is above 150% Federal Poverty Level (FPL); and

(5) provide verification of income to determine enrollment fee, co-pay, and eligibility for the manufacturer's PAP.

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OAC 317:30-5-180.3

317:30-5-180.3. Services

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

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

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OAC 317:30-5-180.4

317:30-5-180.4. Fraud

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

**MEDICAL PROVIDERS-FEE FOR SERVICE
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DISCOUNT PROGRAM**

OAC 317:30-5-180.5

317:30-5-180.5. Pharmacy Benefit Manager

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

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

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

317:30-5-211. Coverage for adults

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

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

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

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

(C) **Provision of DME.**

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

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

(D) **Prior authorization.**

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

before extending beyond five months of rental.

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

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

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

(i) hospital beds,

(ii) support surfaces,

(iii) wheelchairs,

(iv) continuous positive airway pressure devices, (BIPAP & CPAP)

(v) lift devices,

(vi) lymphedema pumps,

(vii) external infusion pumps, and

(viii) osteogenesis stimulators.

(2) **Adaptive equipment for ICF/MR residents.** Payment is made for certain adaptive equipment, for persons residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR). Adaptive equipment is defined as medically necessary equipment

(equipment, appliances and prosthetic devices) required because of physical disabilities. To be covered, adaptive equipment must be unique, individualized or personalized to a specific individual resident. This would include modified equipment or devices to assist in ambulation. Standard wheelchairs, walkers, eyeglasses, etc. would not be considered adaptive equipment. All adaptive equipment must be prescribed by a physician, and prior authorization is required.

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

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

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

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

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

- (i) oxygen
- (ii) catheters and catheter accessories
- (iii) intravenous feeding supplies (see prosthetic devices/hyperalimentation for coverage of food

supplements)

(iv) colostomy and urostomy bags and accessories

(v) tracheotomy supplies

(vi) external breast prostheses and support accessories.

(D) Special requirements.

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

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

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

(A) Catheters. Payment is made for permanent indwelling catheters, male external catheters, drain bags and irrigation trays. Payment is also made for single use self catheters when the patient has a history of urinary tract infections. The prescription from the attending physician indicates that such documentation is available in the patient's medical record.

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

(C) Tracheotomy supplies. Tracheotomy supplies are covered.

(D) Home dialysis. Equipment and supplies are covered for

patients receiving home dialysis treatments.

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

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

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

(i) Payment is made for:

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

(II) two mastectomy bras per year; and

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

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

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

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

(iv) A breast prosthesis can be replaced if:

(I) it is lost;

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

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

(v) External breast prostheses are not covered once breast

reconstruction is performed.

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

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

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

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

(iii) Prescription for oxygen. Prescription for oxygen services must be updated annually or any time a change in prescription occurs. All DME suppliers will be responsible for maintaining the prescription(s) of oxygen services (HCFA-484, Certificate of Medical Necessity for Oxygen) in each Medicaid recipient file. If any change in prescription occurs, the physician must complete a new HCFA-484 and this must be maintained in the recipient files by the DME supplier. The Surveillance and Utilization Review System (SURS) will conduct on going monitoring of prescriptions for oxygen services to ensure

Medicaid guidelines are followed. Recoupment will be made on any cases not meeting the requirements.

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

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

(1) Sales taxes,

(2) Enteral therapy and nutritional supplies and other food supplements, and

(3) Electro-spinal orthosis system (ESO).

(c) **Prior authorization.**

(1) Prosthetic devices, except for cataract lenses, require prior authorization.

(2) Total parenteral therapy is considered a prosthetic device and requires prior authorization. The request for prior authorization must include a fully completed Certificate of Medical Necessity, Form HCFA-852, including information from the attending physician regarding the patient=s medical condition that necessitates the hyperalimentation and the expected length of treatment.

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

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

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

(2) The medical supplier must have a fully completed current

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

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

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

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

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

(2) Capital resources are evaluated on a monthly basis in determining eligibility for an applicant for medical services. An applicant is determined ineligible for any month resources exceed the resource standard at any time during that month. When a member has resources which exceed the resource standard, case closure action is taken for the next possible effective date. #1

(3) State law is specific on the mutual responsibility of spouses for each other. Therefore, if husband and wife are living together, a capital resource and/or income available to one spouse constitutes a resource and/or income to the other. When there is a break in the family relationship and the husband and wife are separated, but not divorced or legally separated, they constitute a possible resource to each other and this possible resource is explored to determine what, if any, resource can be made available. #1 When spouse is in a nursing facility, see Subchapter 9 and 19 of this Chapter.

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

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

(6) Each time that need is determined, gross income and the equity of each capital resource are established. Equity equals current market value minus indebtedness. The member may change

the form of capital resources from time to time without affecting eligibility so long as the equity is not decreased in doing so or increased in excess of the allowable maximum reserve. In the event the equity is decreased as the result of a sale or transfer, the reduction in the equity is evaluated in relation to policy applicable to resources disposed of while receiving assistance. #2

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

(1) Generally, a resource is considered unavailable if there is a legal impediment to overcome. However, the member must agree to pursue all reasonable steps to initiate legal action within 30 days. While the legal action is in process, the resource is considered unavailable.

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

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

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

(c) **Home/real property.** Home property is excluded from resources regardless of value. For purposes of the home property resource exclusion, a home is defined as any shelter in which the individual has an ownership interest and which is used by the individual as his/her principal place of residence. The home may be either real or personal property, fixed or mobile. Home property includes all property which is adjacent to the home. #3 Home property in a revocable trust under the direct control of the individual, spouse, or legal representative retains the exemption as outlined in OAC 317:35-5-41(c)(6). Property has a value regardless of whether there is an actual offer to purchase. Verification of home/real property value is established by collateral contacts with specialized individuals knowledgeable in the type and location of

property being considered.

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

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

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

(4) At the point a member decides not to reinvest the proceeds

from the sale of his/her home in another home, the member's plan for use of the proceeds is evaluated in relation to rules on resources disposed of while receiving assistance.

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

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

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

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

(i) the 12 months of home exemption begins effective with the date of entry into the nursing home regardless of when application is made for SoonerCare benefits, and **#4**

(ii) after 12 months of nursing care, it is assumed there

is no reasonable expectation the member will be discharged from the facility and return home and a lien may be filed against real property owned by the member for the cost of medical services received.

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

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

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

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

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

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

(7) Mineral rights associated with the home property are considered along with the surface rights and are excluded as a resource. However, mineral rights which are not associated with the home property are considered as a resource. Since evaluation and scalability of mineral rights fluctuate, the establishment of the value of mineral rights are established

based on the opinion of collateral sources. Actual offers of purchase are used when established as a legitimate offer through a collateral source. Mineral rights not associated with home property which are income producing are considered in the same way as income producing property.

(8) The market value of real estate other than home property owned by the member or legal dependent and encumbrances against such property are ascertained in determining the equity (including the cost to the member of a merchantable title to be determined when the reserve approaches the maximum). The market value of real estate other than the home owned by the applicant is established on the basis of oral and/or written information which the applicant has on hand **and** counsel with persons who have specialized knowledge about this kind of resource. Refer to (12) of this subsection for exclusion of real estate that produces income.

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

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

(A) When a life estate in property is not used as the member's home, it is necessary to establish the value. A computer procedure is available to compute the value of a life estate by input of the current market value of the property and the age of the life estate owner. **#5**

(B) The value of a life estate on mortgaged property is based

on equity rather than market value and the age of the individual.

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

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

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

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

(B) **Non-trade or non-business property.** Property which produces income but is not used in a trade or business is excluded if the total equity value does not exceed \$6000, and

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

(d) Personal property.

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

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

(A) Checking accounts may or may not represent savings. Current bank statements are evaluated with the member to establish what, if any, portion of the account represents savings. Any income which has been deposited during the current month is not considered unless it exceeds what is considered as ordinary maintenance expense for the month.

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

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

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

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

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

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

(E) If an individual has a life insurance policy which allows death benefits to be received while living, and the individual meets the insurance company's requirements for receiving such proceeds, the individual is not required to file for such proceeds. However, if the individual does file for and receive the benefits, the payment will be considered as income in the month it is received and countable as a

resource in the following months to the extent it is available. The payment of such benefits is not considered a conversion of a resource because the cash surrender value of the insurance policy is still available to the individual. The individual is in effect, receiving the death benefits and not the cash surrender value.

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

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

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

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

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

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

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

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

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

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

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

(ii) a member may exclude the face value, up to \$7,500, plus accrued interest in any combination of irrevocable contract, revocable prepaid account, designated account or cash value in life insurance policies not used to fund the burial policy, regardless of the face value, provided the cash value in policies and designated accounts does not exceed \$1500. When the amount exceeds \$7,500, the member is ineligible for assistance. Accrued interest is not counted as a part of the \$7,500 limit regardless of when it is accrued. #6

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

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

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

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

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

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

(B) The amount which can be realized from notes and mortgages and similar instruments, if offered for immediate sale, constitutes a reserve. Notes and mortgages and similar instruments have value regardless of whether there is an actual offer. Appraisals obtained from bankers, realtors, loan companies and others qualified to make such estimates are obtained in determining current market value. When a total reserve approaches the maximum, it is desirable to get two or more estimates.

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

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

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

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

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

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

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

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

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

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

(vii) **Pour over or open trust**. Pour over or open trust means a trust which may be expanded from time to time by the addition to the trust principal (e.g., a trust established to receive the monthly payment of an annuity, a workers' compensation settlement, a disability benefit or other periodic receivable). The principal may accumulate or grow depending upon whether the trustee distributes the receivable or permits it to accumulate. Generally, the terms of the trust will determine the availability of the income in the month of receipt and the availability of the principal in subsequent months.

(viii) **Primary beneficiary**. Primary beneficiary means the first person or class of persons to receive the benefits of the trust.

(ix) **Revocable trust**. Revocable trust means a trust in which the grantor has retained the right to terminate or revoke the trust and reclaim the trust principal and income. Unless a trust is specifically made irrevocable, it is revocable. Even an irrevocable trust is revocable upon the written consent of all living persons with an interest in the trust.

(x) **Secondary beneficiary**. Secondary beneficiary means the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died or is otherwise no longer entitled to benefits.

(xi) **Testamentary trust**. Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.

(xii) **Trustee**. Trustee means an individual, individuals,

a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.

(C) **Documents needed.** To determine the availability of a trust for an individual applying for or receiving SoonerCare, copies of the following documents are obtained:

(i) Trust document;

(ii) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and

(iii) Documentation reflecting prior disbursements (date, amount, purpose).

(D) **Trust accounts established on or before August 10, 1993.** The rules found in (i) - (iii) of this subparagraph apply to trust accounts established on or before August 10, 1993.

(i) **Support trust.** The purpose of a support trust is the provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (I)-(III) of this unit, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary.

The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:

(I) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;

(II) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide

support out of the trust; and

(III) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available.

If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that SoonerCare benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

(ii) **Medicaid Qualifying Trust (MQT).** A Medicaid Qualifying Trust is a trust, or similar legal device, established (other than by will) by an individual or an individual's spouse, under which the individual may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the individual. A trust established by an individual or an individual's spouse includes trusts created or approved by a representative of the individual (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the individual or the individual's spouse. This includes trust accounts or similar devices established for a minor child pursuant to Title 12 Oklahoma Statute ' 83. In addition, a trust established jointly by at least one of the individuals who can establish an MQT and another party or parties (who do not qualify as one of these individuals) is an MQT as long as it meets the other MQT criteria. The amount from an irrevocable MQT deemed available to the individual is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee(s). The provisions regarding MQT apply even though an MQT is irrevocable or is established for purposes other than enabling an individual to qualify for SoonerCare; and, whether or not discretion is actually

exercised.

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

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

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

(IV) **Transfer of resources.** If the MQT is irrevocable, a transfer of resources has occurred to the extent that the trustee's access to the principal (for purposes of distributing it to the member or using it for the member's benefit) is restricted (e.g., if the trust stipulates that the trustee cannot access the principal but must distribute the income produced by that principal to the member, the principal is not an available resource and has, therefore, been transferred).

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

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

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

(I) the individual;

(II) the individual's spouse;

(III) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

(IV) a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

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

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

(I) In the case of a revocable trust, the principal is considered an available resource to the individual. Home property in a revocable trust under the direct control of the individual, spouse or legal representative retains the exemption as outlined in OAC 317:35-5-41(c)(6). Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the 60 months look back period.

(II) In the case of an irrevocable trust, if there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the principal of the trust, or the income on the principal, from which payment to the individual could be made shall be considered available resources. Payments from the principal or income of the trust shall be considered income of the individual.

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

look back period.

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

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

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

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

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

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

(V) Establishment of this type of trust does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under the age of 65.

(VI) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food, clothing and shelter. Accordingly, any payments made directly to the individual are counted as income

to the individual because the payments could be used for food, clothing, or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food, clothing, or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(II) The trust must be made irrevocable;

(III) The trust must be approved by the Oklahoma Department of Human Services and may not be amended without the permission of the Oklahoma Department of Human Services;

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

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

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

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

(VIII) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts an amount equal to the total medical assistance paid on behalf of the

individual. A maximum of 30% of the amount remaining in the beneficiary=s account at the time of the beneficiary=s death may be retained by the trust.

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

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

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

(A) **Annuities.**

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

would be considered income to the individual. Any portion of the principal of the annuity that could be paid to or on behalf of the individual would be treated as a resource to the individual and portions of the annuity that cannot be paid to or for the benefit of the individual are treated as transfers of assets. Annuities may also be a transfer of assets for less than fair market value. The worker determines, in accordance with the OKDHS life expectancy tables, #8 whether the member will receive fair market value from the annuity during his/her projected lifetime. Any funds used to purchase the annuity that will not be repaid to the member during his/her projected lifetime, are a transfer of assets and the appropriate penalty period is imposed. #8

(ii) Annuities purchased after January 31, 2005.

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

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

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

(i) **Countability of asset.** In each case, the document governing the retirement instrument must be examined to determine the availability of the retirement benefit at the time of application. Retirement benefits are considered countable resources if the benefits are

available to the applicant and/or spouse. Availability means that the applicant and/or spouse has an option to receive retirement benefits or is actually receiving benefits. For example, a retirement instrument may make a fund available at the time of termination of employment, at age 65, or at some other time. A retirement fund is not a countable resource if the applicant is currently working and must terminate employment in order to receive benefits. An individual may have the choice of withdrawing the monies from the retirement fund in a single payment or periodic payments (i.e., monthly, quarterly, etc.). If the individual elects to receive a periodic payment, the payments are considered as income as provided in OAC 317:35-5-42(c)(3). If the monies are received as a lump sum, the rules at OAC 317:35-5-42(c)(3)(C)(i) apply.

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

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

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

(A) **Exempt automobiles.** One automobile is excluded from counting as a resource to the extent its current market value

(CMV) does not exceed \$4,500. The CMV in excess of \$4,500 is counted against the resource limit; or exempt one automobile, pickup or truck per family regardless of the value if it is verified that the car is used:

(i) for medical services 4 times a year to obtain either medical treatment or prescription drugs; or

(ii) for employment purposes; or

(iii) especially equipped for operation by or transportation of a handicapped person.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

of 1937, as amended;

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

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

(O) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments and disaster assistance organizations;

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

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

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

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

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

(U) Dedicated bank accounts established by representative payees to receive and maintain retroactive SSI benefits for disabled/blind children up to the legal age of 18. The

dedicated bank account must be in a financial institution, the sole purpose of which is to receive and maintain SSI underpayments which are required or allowed to be deposited into such an account. The account must be set up and verification provided to SSA before the underpayment can be released; and

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

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

(1) **Resources of an applicant.** If the resource(s) of an applicant is in a form which is not available for immediate use, such as real estate, mineral rights, or one of many other forms, and the applicant is trying to make the resource available, the applicant may be certified and given a reasonable amount of time to make this available. A reasonable amount of time would normally not exceed 90 days. The member is notified in writing that a period of time not to exceed 90 days will be given to make the resource available. Any extension beyond the initial 90-day period is justified only after interviewing the member, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the member.

(2) **Capital resources acquired while receiving assistance.** If the member acquires resources which increase his/her available reserve above the maximum, he/she is ineligible for assistance unless there are specific plans for using the resources in compliance with rules on "resources disposed of while receiving assistance". The term "using the resource" is construed to mean that the resource has been encumbered or actually transferred. If the facts show a reasonable delay in executing the plan to

use the required resource or if the resource is in a form which is not available for immediate use (such as real estate, mineral rights, or one of many other forms), and if efforts are in progress to make the resource available, the member is given a reasonable amount of time to make this available. The member is notified in writing that a period of time not to exceed 90 days will be given to make the resources available. #9

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

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

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

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

(2) If the minor blind or disabled child:

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

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

(3) Premature infants (i.e., 37 weeks or less) whose birth

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

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

INSTRUCTIONS TO STAFF

1. When the applicant is in a NF, see OAC 317:35-19-21. If the individual is receiving ADvantage Services, see OAC 317:35-17-11.
2. See OAC 317:35-5-41(e).
3. Property that is separated from the home by a street, highway, stream or other body of water, etc., is considered part of the home property.
4. Example: Client is admitted to the facility 10-28-92 and the 12-month exclusion ends 10-29-93. Appropriate case action to end the exemption of home property is taken effective 11-1-93.
5. For life estate computations, use online transaction LEC. Instructions for this transaction may be viewed by entering M(sp)LEC.
6. The information in 35-5-41(d)(3) is not applicable when determining the amount of irrevocable burial.
7. According to the Oklahoma State Insurance Commission, a funeral home cannot be the beneficiary of a life insurance policy used to fund a burial contract. Therefore, when life insurance is used to fund a burial contract, there must be an irrevocable assignment of proceeds to the funeral home.

8. Refer to DHS Appendix M-13, Medicaid Life Expectancy Table.
9. Detailed documentation in the case record is required.