POLICY TRANSMITTAL NO. 04-53	DATE: SEPTEMBER 28, 2004
OKLAHOMA HEALTH CARE AUTHORITY	DEPARTMENT OF HUMAN SERVICES OFFICE OF PLANNING, POLICY & RESEARCH

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:2-1-1; 2-1-2.2; 20-1-1 through 20-1-3; 30-3-5; 30-3-25; 30-3-26; 30-3-53; 30-3-73; 30-3-76; 30-3-77; 30-5-8; 30-5-11; 30-5-18; 30-5-22; 30-5-24; 30-5-41; 30-5-47; 30-5-72; 30-5-72.1; 30-5-77.1; 30-5-77.2; 30-5-198; 35-5-25; and 35-5-41.

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

Medical Providers-Fee for Service rules are revised to:
(1) more appropriately describe psychiatric services that are necessary to Medicaid recipients. Current rules in the Section state that individual psychotherapy and family therapy are the only compensable services. Revisions will list and clarify the specific types of Medicaid compensable psychiatric services;
(2) extend coverage of phenylketonuria (PKU) formula and amino acid bars to Medicaid eligible adults with a diagnosis of PKU. Phenylketonuria is a genetic metabolic disorder that involves a defect in a person's ability to metabolize protein. Current agency rules include coverage for PKU formula and amino acid bars for children; rule revisions would extend the same benefit to adults with a diagnosis of PKU;
(3) correspond with other existing rule language regarding payment for ultrasounds for pregnant women;
(4) remove references to the SoonerCare plus program which ended effective January 1, 2004 and reflect current procedures in the SoonerCare Choice program;
(5) modify the current dispensing limitation for compensable prescriptions. Revisions would: set the default maximum dispensing quantity for pharmacy claims to a 34 day supply; allow the Drug Utilization Review Board to set maximum dispensing quantities for individual drugs; and authorize the Drug Utilization Review Board to create and maintain a list of drugs called a Maintenance List which are not subject to the 34 day supply limit;
(6) clarify current reimbursement of Medicare crossover claims. Deletions remove erroneous language regarding Hospital Part B reimbursement of co-insurance;
(7) reflect changes in the pharmacy program that have been approved by the agency's Drug Utilization Review Board and

provide consistency in language regarding prior authorization of prescription medications;
(8) comply with federal regulations found in 42 CFR 441.253 and 441.254 regarding payment for the sterilization of mentally competent individuals aged 21 or older. Current rules state that in order for the sterilization of a competent individual over 21 to be compensable under Medicaid, the individual cannot have previously resided in an institution. Federal regulations have been amended to allow for payment for sterilizations of mentally competent individuals aged 21 or older as long as they are not currently institutionalized. Additional revisions will clarify rules regarding retroactive eligibility and correct an erroneous policy reference;
(9) revoke an obsolete section that contains a general list of persons eligible for Medicaid; rules regarding clients' financial eligibility for Medicaid are found in the agency's existing Medical Assistance for Adult and Children-Eligibilty (OAC 317:35) rules. Other revisions allow dentists in Child Health Centers to bill for dental services using the fee-for-service fee schedule; and
(10) clearly state that cosmetic surgical procedures are not compensable for adults. Various procedure codes for adults for cosmetic surgery are also deleted from agency rules.
Grievance Procedures and Process rules are revised to remove references to the SoonerCare plus program which ended effective January 1, 2004 and reflect current procedures in the SoonerCare Choice program.
Employees Benefits Council rules are revoked as this agency no longer has oversight of the Employees Benefits Council. Revocations are needed to remove unnecessary rules from the agency's Administrative Code.
Medical Assistance for Adults and Children-Eligibility rules are revised to comply with federal regulations related to citizenship and alienage.
Medical Assistance for Adults and Children-Eligibility rules regarding resources for individuals categorically related to ABD are revised to clarify and correct procedures for establishing Medicaid Income Pension Trusts that are also known as Miller Trusts. Other revisions are made to provide consistency in rule language.

Original signed on 9-27-04

Mary Stalnaker, Director Family Support Services Division	Marilynn Knott, Administrator Office of Planning, Policy & Research

WF # 04-Z (DT)

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 a "DHS" number, such as personnel policy at DHS:2-1 and personnel rules at OAC 340:2-1. The "340" is the Title number that designates DHS 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, DHS 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, DHS: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) 521-3611.

REMOVE	INSERT
317:2-1-2	317:2-1-2, pages 1-4, revised 6-25-04
317:2-1-2.2	317:2-1-2.2, 1 page only, revised 6-25-04
317:20-1-1	-----
317:20-1-2	-----
317:20-1-3	-----
317:30-3-5	317:30-3-5, pages 1-4, revised 6-25-04
317:30-3-25	317:30-3-25, 1 page only, revised 6-25-04
317:30-3-26	-----
317:30-3-53	317:30-3-53, 1 page only, revised 6-25-04
317:30-3-73	-----
317:30-3-76	-----
317:30-3-77	317:30-3-77, 1 page only, revised 6-25-04
317:30-5-8	317:30-5-8, pages 1-11, revised 6-25-04
317:30-5-11	317:30-5-11, pages 1-2, revised 6-25-04
317:30-5-18	317:30-5-18, 1 page only, revised 6-25-04
317:30-5-22	317:30-5-22, pages 1-3, revised 6-25-04

REMOVE	**INSERT**
317:30-5-24	317:30-5-24, pages 1-3, revised 6-25-04
317:30-5-41	317:30-5-41, pages 1-10, revised 6-25-04
317:30-5-47	317:30-5-47, pages 1-22, revised 6-25-04
317:30-5-72	317:30-5-72, pages 1-2, revised 6-25-04
317:30-5-72.1	317:30-5-72.1, pages 1-3, revised 6-25-04
317:30-5-77.1	317:30-5-77.1, 1 page only, revised 6-25-04
317:30-5-77.2	317:30-5-77.2, pages 1-3, revised 6-25-04
317:30-5-198	317:30-5-198, pages 1-7, revised 6-25-04
317:35-5-25	317:35-5-25, pages 1-8, revised 6-25-04
317:35-5-41	317:35-5-41, pages 1-41, revised 6-25-04

317:2-1-2. Grievance hearings

(a) **Overview.** The grievance procedure allows a recipient to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints. Appealable reviews are listed at Section 317:2-1-2(b). Recipient appeals are first reviewed by a three person program panel that may or may not contact the recipient [Section OAC 317:2-1-2.2(a)]. The recipient appeal next goes to the ALJ. The recipient must appear at this hearing and it is conducted according to Section OAC 317:2-1-2(c). The recipient may then appeal to the CEO, which is a record review at which the recipient does not appear (Section OAC 317:2-1-4). Provider appeals generally go to the ALJ (see Section OAC 317:2-1-2.1) and generally follow the procedure at OAC 317:2-1-2(c).

(b) **Receipt of grievances.**

(1) The Appellant (Appellant is the person or provider who files a grievance) shall file an LD form requesting a grievance hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-1 forms are for recipient complaints, LD-2 forms are for provider grievances and LD-3 forms are for nursing home wage enhancement grievances.) In the case of tax warrant intercept appeals, the Appellant shall file a LD form requesting a grievance hearing within 30 days of written notice sent by the OHCA according to Title 68, Oklahoma Statutes, Section 205.2.

(2) If the LD form is not received within 20 days of the triggering event, OHCA shall send Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD form is not received within 30 days of written notice sent by OHCA according to Title 68, Oklahoma Statutes, Section 205.2, OHCA shall send the Appellant a letter stating the appeal will not be heard because it is untimely.

(3) The staff shall advise the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(4) The docket clerk will send the Appellant and any other necessary party notice which states the hearing location, date, and time.

(c) **ALJ jurisdiction.** The administrative law judge shall have jurisdiction of the following matters:

(1) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(2) Disputes involving the SoonerCare contracts and all contracts or subcontracts with health care providers;

(3) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)(B), (e)(8), and (e)(12);

(4) Petitions for Rulemaking;

(5) Discrimination complaints regarding the Medicaid program;

(6) Appeals to the decision made by the Business Contracts manager related to Purchasing as found at OAC 317:10-1-5, 317:10-1-13, 317:25-1-5, and 317:25-1-12, and other appeal rights granted by contract;

(7) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(8) Fee for Service appeals regarding the furnishing of services, including prior authorizations;

(9) Nursing home contracts which are terminated, denied, or nonrenewed;

(10) Drug rebate appeals;

(11) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority;

(12) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and

(13) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7.

(d) **Hearing, ALJ, and Burden of Proof.**

(1) Hearings shall be conducted in an informal manner without formal rules of evidence or procedure.

(2) No party is required to be represented by an attorney. Recipients may represent themselves or be represented by another party. Corporate entities must authorize a representative to represent a corporation in a hearing.

(3) The OHCA Administrative Law Judge or designee may:

(A) Rule on any requests for extension of time;

(B) Hold pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end in the expeditious disposition of the proceeding;

(C) Require the parties to state their positions concerning the various issues in the proceeding;

(D) Require the parties to produce for examination those relevant witnesses and documents under their control;

(E) Rule on motions and other procedural items;

(F) Regulate the course of the hearing and conduct of the participants;

(G) Establish time limits for the submission of motions or memoranda;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this Chapter which may include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;

(K) Determine the location of the hearing;

(L) Require the parties to be present and tape record the proceedings. In the event of the failure of a party to appear, the ALJ shall determine if good cause exists for the failure to appear. If good cause does not exist the ALJ may find in favor of the party who was present;

(M) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, shall be given to the ALJ with a copy to be given to the requesting party;

(N) Recess and reconvene the hearing;

(O) Set and/or limit the time frame of the hearing;

(P) Reconsider or rehear a matter for good cause shown; and

(Q) Send a copy of the decision by the ALJ to both parties outlining their rights to appeal the decision. The decision letter need not contain findings of fact or conclusions of law.

(4) The burden of proof during the hearing shall be upon the appellant and the ALJ shall decide the case based upon a preponderance of evidence standard as defined by the Oklahoma Supreme Court.

(5) A copy of the decision will be forwarded to the docket clerk.

317:2-1-2.2. Recipient appeals

(a) Hearings will be by a Program Panel, except in the case of tax warrant intercept appeals and proposed administrative sanction appeals (refer to OAC 317:35-13-7).

(1) The Program Panel will be composed of three or more members selected by the ALJ.

(2) The Program Panel may conduct a paper review of the complaint, or, at their option, hold a personal interview with the appellant to discuss the complaint. The Panel has the power to gather information it finds necessary from any available source, and thereafter, render a decision.

(3) The Panel must complete their paper review or conduct their formal personal interview and issue a majority decision within 25 days of the date stamped on the request for hearing.

(4) The Panel's decision shall be in writing and shall be signed by each of the Panel members. The decision shall contain a summary of the complaint and an explanation of the reasoning of the Panel in making their decision. A copy of the decision will be sent to the member outlining the right to appeal the decision. Any appeal of the Panel decision must be instituted within 15 days of the mailing of the adverse ruling, excepting recipient denials which are automatically appealed to the ALJ.

(5) A copy of the decision shall be forwarded to the docket clerk.

(b) Appeal from a decision of the Program Panel will be heard by the Administrative Law Judge. A decision will be rendered by the Administrative Law Judge within twenty (20) days of the appeal to the ALJ.

(c) Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within twenty (20) days of the hearing before the ALJ.

(d) Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions.

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

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

(1) **"Fee-for-service contract"** means the provider agreement specified in OAC 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority and medical providers which provides for a fee with a specified service involved.

(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the Primary Care Case Manager contracts in the SoonerCare Program.

(3) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the Primary Care Case Manager contracts in the SoonerCare Program.

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

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the patient must not be billed and the patient is not responsible for any balance except the amount indicated by OHCA. The only amount a patient may be responsible for is the personal participation as agreed to at the time of determination of eligibility, or the patient may be responsible for services not covered under the medical programs. The amount of personal participation will be shown on the OHCA notification of eligibility. In any event, the patient should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Customer Services.

(3) When potential assignment violations are detected, the

Authority will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the Authority is required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a fee for service contract and also executes a contract with a provider in the Primary Care Case Management program shall adhere to the rules of this subsection regarding assignment.

(1) If the service provided to the recipient is within the scope of the services outlined in the SoonerCare Contract, the recipient shall not be billed for the service. In this case, the provider shall pursue collection from the Primary Care Physician in the case of the SoonerCare Program.

(2) If the service provided to the recipient is outside of the scope of the services outlined in the SoonerCare Contract, then the provider may bill or seek collection from the recipient.

(3) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) and (2) of this subsection, the Oklahoma Health Care Authority shall be the final authority for this decision. The provider seeking payment under the SoonerCare Program may appeal to OHCA under the provisions of OAC 317:2-1-2.1.

(4) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.

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

collect the copayment.

(1) Copayment is not required of the following recipients:

(A) Individuals under age 21. Each recipient's date of birth is available on the REVS system or through a commercial swipe card system.

(B) Recipients in nursing facilities and intermediate care facilities for the mentally retarded.

(C) Pregnant women.

(D) Home and Community Based Waiver service recipients except for prescription drugs.

(2) Copayment is not required for the following services:

(A) Family planning services. Includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(3) Copayments required include:

(A) $3.00 per day for inpatient hospital services.

(B) $3.00 per day for outpatient hospital services.

(C) $3.00 per day for ambulatory surgery services including free-standing ambulatory surgery centers.

(D) $1.00 for each service rendered by the following providers:

(i) Physicians,

(ii) Optometrists,

(iii) Home Health Agencies,

(iv) Rural Health Clinics,

(v) Certified Registered Nurse Anesthetists, and

(vi) Federally Qualified Health Centers.

(E) Prescription drugs.

(i) $1.00 for prescriptions having a Medicaid allowable of $29.99 or less.

(ii) $2.00 for prescriptions having a Medicaid allowable of $30.00 or more.

(F) Crossover claims. Dually eligible Medicare/Medicaid recipients must make a copayment of $.50 per service for all Part B covered services. This does not include dually eligible HCBW service recipients.

317:30-3-25. Crossovers (coinsurance and deductible)

(a) **Medicare Part A.** Payment is made for Medicare Part A deductible and coinsurance on behalf of eligible individuals.

(b) **Medicare Part B.** Payment is made on behalf of eligible individuals for Medicare Part B coinsurance and/or deductible due after payment has been made by Medicare. Assigned claims from Oklahoma providers automatically cross over from the Medicare carrier. Payment is made utilizing the Medicaid allowable for comparable services.

317:30-3-53. Dental services

At a minimum, dental services include relief of pain and infection; restoration of teeth and maintenance of dental health; and/or oral prophylaxis one each 12 months. Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures. Other dental services include inpatient services in an eligible participating hospital, amalgam and composite restorations, pulpotomies, chrome steel crowns, anterior root canals, pulpectomies, band and loop space maintainers, cement bases, acrylic flippers and lingual arch bars; other restoration, repair and/or replacement of dental defects after the treatment plan submitted by a dentist has been authorized. (Refer to OAC 317:30-5-695 for amount, duration and scope.)

317:30-3-77. Notification of needed medical services

(a) When an individual not currently eligible, including Medicare eligible individuals, requests the physician and/or hospital to bill the Authority for medical services, Form MS-MA-5, Notification of Needed Medical Services, may be completed by the physician and a designated representative of the facility which is to provide the medical services or the patient, parent or guardian may make application by completing an Application for Medical Services. The original forms are routed to the Oklahoma Department of Human Services office in the county of the patient's residence for determination of eligibility. The date of the application is the date the first form received is stamped into the local OKDHS county office. If the patient is in the hospital, application should be made while the patient is still in the hospital, if at all possible.

(b) For pregnant women requesting medical services, Form MS-MA-5 is not required, but will be accepted as medical verification of pregnancy. If Form MS-MA-5 is not completed, a letter or written statement from the physician or certified nurse midwife is acceptable. Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is pregnant. The expected date of delivery must also be established. This can be established from either medical information from the physician or nurse midwife or, in absence of these reports, the applicant's statement.

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 patient 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 Medicaid must not make payment

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

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

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

(i) **General surgery information.**

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

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

(3) When multiple surgery involves tubal ligation, removal of tubes and ovaries, or other procedures for which specific codes exist, the regular procedure code is to be used. The proper consent form must also accompany these claims. If the multiple surgery on a person 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 persons under 21 years of age. A postpartum tubal ligation (Procedure Code 58605) is paid at one hundred percent of the allowable charge if the patient is over 21 years of age and the claim is accompanied by an acceptable consent form.

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

procedure.

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

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

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

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

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

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

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

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

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

(9) Payment 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. Under most circumstances, payment for the immediate pre-operative visit within 24 hours in the hospital, or elsewhere to examine the patient, complete the hospital records and initiate the treatment program, is included

in the listed value for the surgery. All surgical procedures are considered to include normal, uncomplicated follow-up care unless otherwise indicated. The Combined Procedures Terminology manual identifies most of these procedures with a star.

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

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

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

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

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

(B) If the data plots above the 22nd percentile, the procedure is considered medically necessary. If the data plots between the 5th and 22nd percentiles, medical necessity would be questioned and referred to the Agency's Medical Director for review. If below the 5th percentile, the

procedure is considered cosmetic and not eligible for coverage.

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

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

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

(II) Chronic back and/or neck pain;

(III) Breast pain;

(IV) Intertrigo;

(V) Documented weight loss program if applicable.

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

(I) Patient's height and weight;

(II) Front and side view photographs;

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

(IV) Diagnosis; and

(V) CPT Code.

317:30-5-11. Psychiatric services

(a) Payment is made for procedure codes listed in the Psychiatry Series of the most recent edition of the CPT codes. The codes in this service range are accepted services within the Medicaid program for children and adults with the following exceptions:

(1) Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.

(2) Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient.

(3) Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers.

(4) Unlisted psychiatric service or procedure.

(b) All services must be medically necessary and appropriate and include a DSM multi axial diagnosis completed for all five axes from the most recent version of the DSM.

(c) Services in the psychiatry series of the CPT manual must be provided by a board eligible or board certified psychiatrist or a physician, physician assistant, or nurse practitioner with additional training that demonstrates the knowledge to conduct the service performed. Documentation of training for physicians who are not board eligible or board certified psychiatrists should be submitted to the Medical Director of the OHCA.

(d) No services in the psychiatry series of the CPT manual may be provided via telemedicine or other electronic medium, with the exception of "pharmacologic management". Pharmacological management may be performed via telemedicine under the following circumstances:

(1) A healthcare professional with knowledge of the patient must accompany and attend the patient during the performance of the service.

(2) The psychiatrist performing the service or in the case of a group practice or agency, another psychiatrist within that practice or agency must have seen the patient receiving the service during either a psychiatric exam or previous pharmacologic management session or other face-to-face psychiatric service.

(3) The patient must understand the procedure including the technologic aspects of the process and agree, in writing, to having his/her pharmacological management session via electronic equipment.

(e) The telecommunications equipment must provide clear images of the psychiatrist to the patient. The psychiatrist must have a clear visual field to effectively evaluate the physical condition of the patient, including but not limited to extrapyramidal symptoms, injuries and changes in weight. Audio reception must be sufficient for the patient and physician to clearly hear one another's conversation.

317:30-5-18. Elective sterilizations

(a) Payment is made for elective sterilizations performed in behalf of eligible individuals if all of the following circumstances are met:

(1) The patient must be at least 21 years of age at the time the consent form is signed;

(2) The patient must be mentally competent, and not presently institutionalized;

(3) A properly completed Federally mandated consent for sterilization form is attached to the claim; and

(4) The form is signed and dated at least 30 days, but not more than 180 days prior to surgery.

(b) When a sterilization procedure is performed in conjunction with a C-Section, the appropriate HCPC coding is used to report the procedures performed. A consent form is required when the sterilization procedure is performed.

(c) Reversal of sterilization procedures for the purpose of conception are not covered. Reversal of sterilization procedures may be covered when medically indicated and substantiating documentation is attached to the claim.

(d) The ADM-71 consent form was developed to meet federal requirements.

317:30-5-22. Obstetrical care

(a) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total obstetrical care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the patient leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the antepartum visits. The antepartum care during the prenatal care period includes all care by the OB attending physician except major illness distinctly unrelated to the pregnancy.

(b) Procedures paid separately from total obstetrical care are listed in (1) - (6) of this subsection.

(1) Level I - Complete Ultrasound: Payment will be made separately from the total obstetrical care for one complete ultrasound per pregnancy when the patient has been referred to a radiologist or maternal fetal specialist trained in ultrasonography. The patient's record must be documented as to the reason the ultrasound was requested and the components of the ultrasound. The appropriate HCPC code must be used.

(2) Level II - Targeted Ultrasound: Payment will be made separately from the total obstetrical care for one medically necessary targeted ultrasound per pregnancy for high risk pregnancies. Documentation as to the medical justification must be made a part of the patient's record. The targeted ultrasound must be performed:

(A) with equipment capable of producing targeted quality evaluations; and

(B) by an obstetrician certified by the American Board of Obstetrics and Gynecology as a diplomat with special qualifications in maternal fetal medicine or an active candidate for certification in maternal fetal medicine.

(C) a complete ultrasound code is used if during the procedure it is apparent that a targeted ultrasound is not medically necessary.

(3) Standby attendance at C-Section, for the purpose of attending the baby, is compensable when billed by a physician not participating in the delivery.

(4) Spinal anesthesia administered by the attending physician is a compensable service and should be billed separately from the delivery.

(5) Amniocentesis is not included in routine obstetrical care and should be billed separately.

(6) Additional payment is not made for the delivery of twins. If one twin is delivered vaginally and one is delivered by C-section by the same physician, the higher level procedure is paid. If one twin is delivered vaginally and one twin delivered by C-Section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment will not be made to the same physician for both standby and assistant at C-Section.

(c) Assistant surgeons will be paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at C-Section should bill separately for the prenatal and the six weeks postpartum office visit.

(d) Procedures listed in (1) - (5) of this subsection are not paid or not covered separately from total obstetrical care.

(1) An additional allowance may not be made for induction of labor, double set-up examinations, fetal stress and non-stress tests, or pudendal anesthetic. Do not bill separately for these procedures.

(2) Standby at C-Section is not compensable when billed by a physician participating in delivery.

(3) Payment is not made for assistant surgery for obstetrical procedures which include prenatal or post partum care.

(4) Pitocin induction of labor is considered part of the

delivery and separate payment is not made.

(5) Fetal scalp blood sampling is considered part of the total OB care.

317:30-5-24. Radiology

(a) **Outpatient and emergency department.**

(1) The technical component of outpatient radiological services performed during an emergency department visit is included in the emergency department case rate paid to the hospital.

(2) The professional component of x-rays performed during an emergency department visit is covered.

(3) Payment will be made separately from the total obstetrical care for one Level I complete ultrasound per pregnancy when the patient has been referred to a radiologist or maternal fetal specialist trained in ultrasonography. The patient's record must be documented as to the reason the ultrasound was requested and the components of the ultrasound. The appropriate HCPC code must be used. Payment will be made separately from the total obstetrical care for one medically necessary targeted ultrasound per pregnancy for high risk pregnancies. Documentation as to the medical justification must be made a part of the patient's record. The targeted ultrasound must be performed:

(A) with equipment capable of producing targeted quality evaluations; and

(B) by an obstetrician certified by the American Board of Obstetrics and Gynecology as a diplomat with special qualifications in maternal fetal medicine.

(C) a complete ultrasound code is used if during the procedure it is apparent that a targeted ultrasound is not medically necessary.

(4) Outpatient chemotherapy is compensable for proven malignancies and opportunistic infections. Outpatient radiation therapy is covered for the treatment of proven malignancies or when treating benign conditions utilizing sterotactic radiosurgery (e.g., gamma knife).

(5) One screening mammogram and one follow-up mammogram every year for women beginning at age 30. Additional follow-up mammograms are covered when medically necessary. A prior authorization by the Medical Professional Services Division of the Oklahoma Health Care Authority is required for additional

follow-up mammograms.

(b) **Inpatient procedures.** Inpatient radiological procedures are compensable if done on a referral basis. Claims for inpatient interpretations by the attending physician are not compensable unless the attending physician reads interpretations for the hospital on all patients.

(c) **Inpatient radiology performed outside of hospital.** When patient is an inpatient but has to be taken elsewhere for an x-ray, such as to an office or another hospital because the admitting hospital did not have proper equipment, the place of service should still be IH, since the patient is considered to be in the hospital at the time of service.

(d) **Radiology therapy management.** Weekly clinical management is based on five fractions delivered comprising one week regardless of the time interval separating the delivery of treatments. Weekly clinical management should be billed as one unit of service rather than five.

(e) **Miscellaneous.**

(1) **Arteriograms, angiograms and aortograms.** When arteriograms, angiograms or aortograms are performed by a radiologist, they are considered radiology, not surgery.

(2) **Injection procedure for arteriograms, angiograms and aortograms.** The "interpretation only" code and the "complete procedure" code are not both allowed for one of these procedures.

(3) **Evac-U-Kit or Evac-O-Kit.** Evac-U-Kit and Evac-O-Kit are included in the charge for the Barium Enema.

(4) **Examination.** Examination at bedside or in operating room allows an additional charge to be made. Examination outside regular hours is not a covered charge.

(5) **Supplies.** Separate payment is not made for supplies such as "administration set" used in provision of office chemotherapy.

(6) **Fluoroscopy or Esophagus study.** Separate charge for fluoroscopy or esophagus study in addition to a routine

gastrointestinal tract examination is not covered unless a report is submitted indicating an esophagram was done as a separate procedure.

(f) **Magnetic Resonance Imaging.** MRI/MRA scans are covered when medically necessary. Documentation in the progress notes must reflect the medical necessity. The diagnosis code must be shown on the claim.

(g) **Placement of radium or other radioactive material.**

(1) For Radium Application use the appropriate HCPCS code.

(2) When a physician supplies the therapeutic radionuclides (implant grains or Gold Seeds) and provides a copy of the invoice, payment will be made at 100% of the invoice charges. Fee may include cost of radium, container, and shipping and handling.

317:30-5-41. Coverage for adults

For persons 21 years of age or older, payment is made to hospitals for services as described in this Section.

(1) **Inpatient hospital services.**

(A) Effective August 1, 2000, all general inpatient hospital services for all persons 21 years of age or older is limited to 24 days per person per state fiscal year (July 1 through June 30). The 24 day limitation applies to both hospital and physician services. No exceptions or extensions will be made to the 24 day inpatient services limitation.

(B) Effective October 1, 1993, inpatient chemical detoxification (alcohol or drugs) for persons age 21 and older is limited to a maximum of five days and subject to post-payment review. No continued stay in inpatient chemical detoxification is allowed.

(C) Effective October 1, 1993, inpatient chemical dependency treatment (alcohol or drugs) for persons age 21 and older is not covered.

(D) All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment.

(i) It is the policy and intent to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a Medicaid recipient. If the OHCA, or its designated agent, upon their initial review determines the admission should be denied, a notice is sent to the facility and the attending physician(s) advising them of the decision. This notice also advises that a reconsideration request may be submitted within 60 days. Additional information submitted with the reconsideration request will be reviewed by the OHCA, or its designated agent, who utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, OHCA is informed. At that point, OHCA sends

a letter to the hospital and physician requesting refund of the Medicaid payment previously made on the denied admission.

(ii) If the hospital or attending physician did not request reconsideration by the OHCA, or its designated agent, the OHCA, or its designated agent, informs OHCA that there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, sends a letter to the hospital and physician requesting refund of the amount of Medicaid payment previously made on the denied admission.

(iii) If an OHCA, or its designated agent, review results in denial and the denial is upheld throughout the appeal process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services.

(E) If a hospital or physician believes that an acute care hospital admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient insists on treatment, the patient should be informed that he/she will be personally responsible for all charges. If a Medicaid claim is filed and paid and the service is later denied the patient is not responsible. If a Medicaid claim is not filed and paid the patient can be billed.

(F) Payment is made to a participating hospital for hospital based physician's services. The hospital must have a Hospital-Based Physician's Contract with OHCA for this method of billing.

(2) **Outpatient hospital services.**

(A) **Emergency hospital services.** Emergency department services are covered. Payment is made at a case rate which includes all non-physician services provided during the visit.

(B) **Level I - Complete Ultrasound.** Payment will be made separately from the total obstetrical care for one complete ultrasound per pregnancy when the patient has been referred to a radiologist or maternal fetal specialist trained in ultrasonography. The patient's record must be documented as

to the reason the ultrasound was requested and the components of the ultrasound. The appropriate HCPC code must be used.

(C) **Level II - Targeted Ultrasound.** Payment will be made separately from the total obstetrical care for one medically necessary targeted ultrasound per pregnancy for high risk pregnancies. Documentation as to the medical justification must be made a part of the patient's record. The targeted ultrasound must be performed:

(i) with equipment capable of producing targeted quality evaluations; and

(ii) by an obstetrician certified by the American Board of Obstetrics and Gynecology as a diplomat with special qualifications in maternal fetal medicine or an active candidate for certification in maternal fetal medicine.

(iii) a complete ultrasound code is used if during the procedure it is apparent that a targeted ultrasound is not medically necessary.

(D) **Dialysis.** Payment for dialysis is made at the Medicare allowable facility rate. This rate includes all services which Medicare has established as an integral part of the dialysis procedure, such as routing medical supplies, certain laboratory procedures, oxygen, etc. Payment is made separately for injections of Epoetin Alfa (EPO or Epogen).

(E) **Technical component.** Payment is made for the technical component of outpatient radiation therapy and compensable x-ray procedures.

(F) **Laboratory.** Payment is made for medically necessary outpatient services.

(G) **Blood.** Payment is made for outpatient blood and blood fractions when these products are required for the treatment of a congenital or acquired disease of the blood.

(H) **Ambulance.**

(I) **Pharmacy.**

(J) **Home health care.** Hospital based home health providers must be Medicare certified and have a current Home Health Agency contract with the Oklahoma Health Care Authority.

(i) Payment is made for home health services provided in a patient's residence to all categorically needy individuals.

(ii) Payment is made for a maximum of 36 visits per year per eligible recipient.

(iii) Payment is made for standard medical supplies.

(iv) Payment is made on a rental or purchase basis for equipment and appliances suitable for use in the home.

(v) Non-covered items include sales tax, enteral therapy and nutritional supplies, and electro-spinal orthosis systems (ESO).

(vi) Payment may be made at a statewide procedure based rate. Payment for any combination of skilled and home health aide visits shall not exceed 36 visits per year.

(vii) Payment may be made to home health agencies for prosthetic devices.

(I) Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. A completed HCFA-484 must accompany the initial claim for oxygen. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is considered most appropriate. Refer to the Medical Suppliers Manual for further information.

(II) Payment is made for permanent indwelling catheters, drain bags, insert trays and irrigation trays. Male external catheters are also covered.

(III) Sterile tracheostomy trays are covered.

(IV) Payment is made for colostomy and urostomy bags and accessories.

(V) Payment is made for hyperalimentation, including supplements, supplies and equipment rental in behalf of persons having permanently inoperative internal body organ dysfunction. CC-17 should be submitted to the Medical Authorization Unit. Information regarding the patient's medical condition that necessitates the hyperalimentation and the expected length of treatment, should be attached.

(VI) Payment is made for ventilator equipment and supplies when prior authorized. CC-17 should be submitted to the Medical Authorization Unit.

(VII) Medical supplies, oxygen, and equipment should be billed using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.

(K) **Outpatient hospital services, not specifically addressed.** Outpatient hospital services, not specifically addressed, are covered for adults only when prior authorized by the Medical Professional Services Unit of the Oklahoma Health Care Authority.

(L) **Outpatient chemotherapy and radiation therapy.** Payment is made for charges incurred for the administration of chemotherapy for the treatment of malignancies and opportunistic infections. Payment for radiation therapy is limited to the treatment of proven malignancies and benign conditions appropriate for sterotactic radiosurgery (e.g., gamma knife).

(M) **Ambulatory surgery.**

(i) **Definition of Ambulatory Surgical Center.** An ambulatory surgical center (ASC) is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients and which enters into an agreement with HCFA to do so. An ASC may be either independent (i.e., not part of a provider of services or any other facility) or may be operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). If an ASC is the latter type it has the option of being covered and certified under Medicare as an ASC, or of being covered as an outpatient

hospital facility. In order to be covered as an ASC operated by a hospital, a facility must:

(I) elect to do so, and continue to be so covered unless HCFA determines there is good cause to do otherwise;

(II) be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital; and

(III) meet all the requirements with regard to health and safety, and agree to the assignment, coverage and reimbursement rules applied to independent ASC's.

(ii) **Certification.** In order to be eligible to enter into an agreement with HCFA to be covered as an ASC, a facility must be surveyed and certified as complying with the conditions for coverage for ASC's in 42 CFR 416.39-49.

(N) **Outpatient surgery services.** The covered facility services are defined as those services furnished by an ASC or OHF in connection with a covered surgical procedure.

(i) **Services included in the facility reimbursement rate.** Services included in the facility reimbursement rate are:

(I) Nursing, technical and other related services. These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the facility. In addition to the nursing staff, this category would include orderlies and others involved in patient care.

(II) Use of the patient of the facility. This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.

(III) Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment. This category includes all supplies and equipment commonly furnished by the facility in connection with surgical procedures, including any drugs and biologicals

administered while the patient is in the facility. Surgical dressings, other supplies, splints, and casts include those furnished by the facility at the time of surgery. Additional supplies and materials furnished later would generally be furnished as incident to a physician's service and not as a facility service. Supplies include those required for both the patient and facility personnel, i.e., gowns, masks, drapes, hoses, scalpels, etc., whether disposable or reusable.

(IV) Diagnostic or therapeutic items and services directly related to the surgical procedure. Payment to the facility includes items and services furnished by facility staff in connection with covered surgical procedures. These diagnostic tests include but are not limited to tests such as urinalysis, blood hemoglobin or hematocrit, CBC and fasting blood sugar, etc.

(V) Administrative, recordkeeping, and housekeeping items and services. These include the general administrative functions necessary to run the facility, such as scheduling, cleaning, utilities, rent, etc.

(VI) Blood, blood plasma, platelets, etc. Under normal circumstances, blood and blood products furnished during the course of the procedure will be included in the payment for the facility charge. In cases of patients with congenital or acquired blood disorders, additional payment can be made within the scope of the Authority's Medical Programs.

(VII) Materials for anesthesia. These include the anesthetic and any materials necessary for its administration.

(ii) **Services not included in facility reimbursement rates**. The following services are not included in the facility reimbursement rate:

(I) Physicians' services. This category includes most services performed in the facility which are not considered facility services. The term physicians' services includes any pre/postoperative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, or other

services which the individual physician usually includes in a set "global" fee for a given surgical procedure.

(II) The sale, lease, or rental of durable medical equipment to facility patients for use in their homes. If the facility furnishes items of DME to patients it should be treated as a DME supplier and these services billed on a separate claim form. Coverage of DME is limited to the scope of the Authority's Medical Programs.

(III) Prosthetic devices. Prosthetic devices, whether implanted, inserted, or otherwise applied by covered surgical procedures are not included in the facility payment. One of the more common prosthesis is intra-ocular lenses (IOL's). Prosthetic devices should be billed as a separate line item using appropriate HCPCS code.

(IV) Ambulance services. If the facility furnishes ambulance services, they are covered separately as ambulance services if otherwise compensable under the Authority's Medical Programs.

(V) Leg, arm, back and neck braces. These items are not included in the facility payment. Payment is limited to the scope of the Authority's Medical Programs.

(VI) Artificial legs, arms, and eyes. This equipment is not considered part of the facility service and is not included in the facility payment rate. Payment is limited to the scope of the Authority's Medical Programs.

(VII) Services of an independent laboratory. Payment for laboratory services is limited to the scope of the Authority's Medical Programs.

(iii) **Reimbursement - facility services**. The facility services are reimbursed according to the group in which the surgical procedure is listed. If more than one surgical procedure is performed at the same setting, reimbursement will be made for only the major procedure.

Reimbursement will be made at a state-wide payment rate based on Medicare's established groups as adapted for Medicaid.

(iv) **Compensable procedures.** The HCPCS codes identify the compensable procedures and should be used in billing.

(O) **Outpatient hospital services for persons infected with tuberculosis (TB).** Outpatient hospital services are covered for persons infected with tuberculosis. Coverage includes, but may not be limited to, outpatient hospital visits, laboratory work and x-rays. Services to persons infected with TB are not limited to the scope of the Medicaid program; however, prior authorization is required for services that exceed the scope of coverage under Medicaid. Drugs prescribed for the treatment of TB not listed in OAC 317:30-3-46 require prior authorization by the University of Oklahoma College of Pharmacy using form "Petition for TB Related Therapy".

(P) **Mammograms.** Medicaid covers one screening mammogram and one follow-up mammogram every year for women beginning at age 30. Additional follow-up mammograms are covered when medically necessary. A prior authorization by the Medical Professional Services Division of the Oklahoma Health Care Authority is required for additional follow-up mammograms.

(3) **Exclusions.** The following are excluded from coverage:

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

(B) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.

(C) Reversal of sterilization procedures for the purposes of conception are not covered.

(D) Medical services considered to be experimental.

(E) Services or any expense incurred for cosmetic surgery including removal of benign skin lesions.

(F) Refractions and visual aids.

(G) Payment for the treatment of obesity.

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement for inpatient hospital services is made based on a prospective per diem level of care payment system. Reimbursement for inpatient care includes services provided to the patient within 72 hours of admission. This includes diagnostic testing, emergency room, observation room, and outpatient surgery charges. The per diem includes all non-physician services furnished either directly or under arrangements. When a patient is taken to another facility with a Medicaid contract for treatment not available at the admitting facility, reimbursement to the treating facility by the admitting facility will be limited to the Medicaid fee schedule. This does not include reimbursement for services in Residential Psychiatric Treatment Facilities.

(1) **Components.** There are two distinct payment components under this system. Total per diem reimbursement under the reimbursement system will equal the sum of:

(A) Level of care per diem; plus

(B) Fixed capital per diem.

(2) **Level of care per diem rates.** The level of care per diem rates are payments for operating costs and movable capital costs. Hospitals with actual costs above the statewide median level of care will be limited to reimbursement of the statewide median level of care rate. The median was calculated by level of care using FY 1988 base year operating and moveable capital costs trended forward to the beginning of the third quarter FY 1991. Beginning July 1, 1993, when a hospital's actual costs are less than the statewide median level of care, 25 percent of the difference between the statewide median level of care rate and the hospital's specific level of care cost will be added to each level of care rate.

(A) **Levels of care**. There are eight levels of care:

(i) Burn Care (Level 1). Presence of burn unit revenue code charges (Revenue code 207);

(ii) Neonatal intensive Care Unit (NICU) (Level 2). Presence of neonatal intensive care unit revenue code charges on NICU claims from Level III providers (Revenue

code 174);

(iii) Maternity care (Level 3). Diagnosis codes;

(iv) Surgical care (Level 4). Presence of surgical revenue code charges (Revenue codes 360 - 369 including C-Sections). (See (B)(ii) of this paragraph for exception to payment of minor surgical procedures);

(v) Rehabilitation care (Level 5). Range of primary and secondary diagnosis codes (Diagnosis codes V57xx - V5799);

(vi) Psychiatric care (Level 6). Range of primary diagnosis codes (Diagnosis codes 290 - 316);

(vii) Intensive Care Unit/Coronary Care Unit (ICU/CCU) (Level 7). Presence of Intensive Care Unit/Coronary Care Unit revenue code charges (Revenue codes 200-206, 208-219);

(viii) Routine care (Level 8). All remaining days (Revenue codes 101, 110 - 179, 186 - 189).

(B) **Claims.** Claims will be classified into each of the eight levels of care based on the hierarchy shown in (A)(i) through (A)(viii) of this paragraph, with claims potentially classifying into Level 1 first, then Level 2, and so forth. Payment of claims classified into Levels 1 - 6 and Level 8 is made at a single level of care rate. For example, if a claim is classified into Level 3, the Maternity level of care, then all covered days submitted on that claim will be made at the Level 3 per diem rate. There are two exceptions to this rule:

(i) Payment of claims classified into Level 7 may be made at two level of care rates. This would occur if a claim is submitted for payment with both ICU/CCU revenue code charges and routine revenue code charges; payment is split between Levels 7 and 8. For example, if a claim is submitted with three covered ICU/CCU days and seven covered routine days, the claim shall be paid three days at the ICU/CCU per diem rate and seven days at the routine per diem rate. However, if a claim is submitted with ten covered ICU/CCU days and no routine days, ten days will be made at the ICU/CCU level of care rate. Claims for a

single stay shall not be split and submitted as two claims solely for the purpose of obtaining two different level of care payment rates (except when patients receiving psychiatric care in acute care hospitals are transferred to medical units because their non-psychiatric medical needs become the primary cause of hospitalization). There are two restrictions on these levels of care:

(I) Only Level III neonatal units will be paid the NICU level of care per diem rate. For rate setting purposes a hospital is considered eligible to receive the level III NICU rate if it meets the criteria used by the Health Planning Commission (now part of the Oklahoma Department of Health) in its 1988 Hospital Utilization and Plan Survey.

(II) All claims from free-standing inpatient psychiatric hospitals will be paid at the Level 6, Psychiatric, level of care rate. (Psychiatric claims from acute care hospitals will also be paid at the Level 6 rate).

(ii) Certain surgical procedures are paid at a lower level of care than the surgery rate. These procedures do not require the same resources as most procedures paid at a surgical rate and are classified as minor surgeries and paid at a routine level of care. When a minor surgery is involved, but a level of care other than routine is indicated, payment will be made at the appropriate level of care. Minor procedures include:

(I) 03.31 Spinal Tap

(II) 03.90 Insertion of catheter into spinal canal for infusion of palliative or therapeutic substance

(III) 03.91 Injection of anesthesia into spinal canal
(IV) 03.92 Injection of other agent into spinal canal

(V) 04.80 Injection of peripheral nerve, NOS

(VI) 04.81 Injection of anesthetic into peripheral nerve for analgesia

(VII) 04.89 Injection of other agent (except

neurolytic)

(VIII) 06.11 Closed (percutaneous) (needle) biopsy of thyroid gland

(IX) 08.81 Linear repair of laceration of eyelid

(X) 14.21 Destruction of chorioretinal lesion by diathermy

(XI) 14.22 Destruction of chorioretinal lesion by cryotherapy

(XII) 14.23 Destruction of chorioretinal lesion by xenon arc photocoagulation

(XIII) 14.24 Destruction of chorioretinal lesion by laser photocoagulation

(XIV) 14.25 Destruction of chorioretinal lesion, unspecified

(XV) 14.26 Destruction of chorioretinal lesion by radiation therapy

(XVI) 14.29 Destruction of chorioretinal lesion, NOS

(XVII) 16.21 Ophthalmoscopy

(XVIII) 18.02 Incision of external auditory canal

(XIX) 18.11 Otoscopy

(XX) 18.12 Biopsy of external ear

(XXI) 18.19 Other diagnostic procedure on external ear

(XXII) 18.4 Suture of laceration of external ear

(XXIII) 20.1 Removal of tympanostomy tube

(XXIV) 20.31 Electrocochiliography

(XXV) 21.00 Control of epistaxis NOS

(XXVI) 21.01 Control of epistaxis by anterior nasal packing

(XXVII) 21.02 Control of epistaxis by posterior and anterior nasal packing

(XXVIII) 21.03 Control of epistaxis by cauterization and packing

(XXIX) 21.22 Biopsy of nose

(XXX) 21.29 Other diagnostic procedure on nose

(XXXI) 21.71 Closed reduction of nasal fracture

(XXXII) 21.81 Suture of laceration of nose

(XXXIII) 22.11 Closed (endoscopic) (needle) biopsy of nasal sinus

(XXXIV) 22.19 Other diagnostic procedure on nasal sinus

(XXXV) 23.2 Restoration of tooth by filling

(XXXVI) 23.3 Restoration of tooth by inlay

(XXXVII) 23.41 Dental restoration by application of crown

(XXXVIII) 23.42 Dental restoration by fixed bridge

(XXXIX) 23.43 Dental restoration by removable bridge
(XL) 23.49 Dental restoration, other

(XLI) 24.11 Biopsy of the gum

(XLII) 24.12 Biopsy of the alveolus

(XLIII) 24.19 Other diagnostic procedures on teeth, gums, alveoli

(XLIV) 24.7 Application of orthodontic appliance

(XLV) 24.8 Other orthodontic operation

(XLVI) 25.01 Closed (needle) biopsy of tongue

(XLVII) 25.09 Other diagnostic procedure on tongue

(XLVIII) 25.51 Suture of laceration of tongue

(IL) 25.91 Lingual frenotomy

(L) 26.11 Closed (needle) biopsy of salivary gland or duct

(LI) 26.19 Other diagnostic procedures on salivary glands and ducts

(LII) 26.91 Probing of salivary duct

(LIII) 27.21 Biopsy of bony palate

(LIV) 27.22 Biopsy of uvula and soft palate

(LV) 27.23 Biopsy of lip

(LVI) 27.24 Biopsy of mouth, unspecified structure

(LVII) 27.29 Other diagnostic procedures on oral cavity

(LVIII) 27.51 Suture of laceration of lip

(LIX) 27.52 Suture of laceration of other part of mouth

(LX) 27.91 Labial frenotomy

(LXI) 31.41 Tracheoscopy through artificial stoma

(LXII) 31.42 Laryngoscopy and other tracheoscopy

(LXIII) 31.43 Closed (endoscopic) biopsy of larynx

(LXIV) 31.44 Closed (endoscopic) biopsy of trachea

(LXV) 33.21 Bronchoscopy through artificial stoma

(LXVI) 33.22 Fiberoptic bronchoscopy

(LXVII) 33.23 Other bronchoscopy

(LXVIII) 33.24 Closed (endoscopic) biopsy of bronchus

(LXIX) 33.91 Bronchial dilation

(LXX) 34.04 Insertion of intercostal catheter for drainage

(LXXI) 34.25 Closed (percutaneous) (needle) biopsy of ediastinum

(LXXII) 34.91 Thoracentesis

(LXXIII) 34.92 Injection into thoracic cavity

(LXXIV) 37.70-37.73 Insertion of leads: NOS, atrium, ventricle, atrium and ventricle

(LXXV) 37.74-37.77 Replacement/revision of leads

(LXXVI) 37.78 Insertion of temporary pacemaker

(LXXVII) 38.91 Arterial catheterization

(LXXVIII) 38.92 Umbilical vein catheterization

(LXXIX) 38.93 Venous catheterization, NOS

(LXXX) 38.94 Venous cutdown

(LXXXI) 38.95 Venous catheterization for renal dialysis

(LXXXII) 38.98 Other puncture of an artery

(LXXXIII) 38.99 Other puncture of vein

(LXXXIV) 39.95 Hemodialysis

(LXXXV) 42.22 Esophagoscopy through artificial stoma

(LXXXVI) 42.23 Other esophagoscopy

(LXXXVII) 42.24 Closed (endoscopic) biopsy of esophagus

(LXXXVIII) 42.92 Dilation of esophagus

(LXXXIX) 44.12 Gastroscopy through artificial stoma

(XC) 44.13 Other gastroscopy

(XCI) 44.14 Closed (endoscopic) biopsy of stomach

(XCII) 44.22 Endoscopic dilation of pylorus

(XCIII) 45.12 Endoscopy of large intestine through artificial stoma

(XCIV) 45.13 EGD

(XCV) 45.14 Closed (endoscopic) biopsy of small intestine

(XCVI) 45.16 EGD with biopsy

(XCVII) 45.22 Endoscopy of large intestine through artificial stoma

(XCVIII) 45.23 Colonoscopy

(IC) 45.24 Flexible sigmoidoscopy

(C) 45.25 Colonoscopy with biopsy

(CI) 45.42 Endoscopic polypectomy of large intestine

(CII) 48.22 Proctosigmoidoscopy through artificial stoma

(CIII) 48.23 Rigid proctosigmoidoscopy

(CIV) 48.24 Closed (endoscopic) biopsy of rectum

(CV) 54.91 Percutaneous abdominal paracentesis

(CVI) 54.98 Peritoneal dialysis

(CVII) 56.31 Ureteroscopy

(CVIII) 56.32 Closed percutaneous biopsy of ureter

(CIX) 56.33 Ureteroscopy with biopsy (endoscopic)

(CX) 57.31 Cystoscopy through artificial stoma

(CXI) 57.32 Other cystoscopy

(CXII) 58.22 Other urethroscopy

(CXIII) 58.31 Urethroscopy with biopsy

(CXIV) 58.6 Dilation of urethra

(CXV) 60.11 Closed (percutaneous) biopsy of prostate

(CXVI) 62.11 Closed (percutaneous) biopsy of testis

(CXVII) 70.0 Culdocentesis

(CXVIII) 70.12 Culdotomy

(CXIX) 70.21 Vaginoscopy

(CXX) 71.3 Other local excision or destruction of vulva and perineum

(CXXI) 79.00-79.09 Closed reduction of fracture (various sites)

(CXXII) 79.70-79.79 Closed reduction of dislocation (various sites)

(CXXIII) 81.91 Arthrocentesis

(CXXIV) 81.92 Injection of therapeutic substance into joint or ligament

(CXXV) 83.21 Biopsy of soft tissue

(CXXVI) 84.41 Fitting of prosthesis, upper arm and shoulder

(CXXVII) 84.42 Fitting of prosthesis, lower arm and hand

(CXXVIII) 84.43 Fitting of prosthesis, arm, NOS

(CXXIX) 84.45-84.47 Fitting of prosthesis, above knee, below knee, leg, NOS

(CXXX) 85.11 Closed (percutaneous) (needle) biopsy of breast

(CXXXI) 85.19 Other diagnostic procedure on breast

(CXXXII) 85.91 Aspiration of breast

(CXXXIII) 85.92 Injection of therapeutic agent into breast

(CXXXIV) 86.01 Aspiration of skin and subcutaneous tissue

(CXXXV) 86.03 Incision of pilonidal sinus or cyst

(CXXXVI) 86.04 Other incision with drainage of skin and subcutaneous tissue

(CXXXVII) 86.07 Insertion of VAD (infusaport)

(CXXXVIII) 86.09 Other incision of skin and subcutaneous tissue

(CXXXIX) 86.11 Biopsy of skin and subcutaneous tissue

(CXL) 86.19 Other diagnostic procedure on skin and subcutaneous tissue

(CXLI) 86.26 Ligation of dermal appendage

(CXLII) 86.28 Non-excisional debridement of wound

(CXLIII) 86.59 Suture of skin and subcutaneous tissue, other sites

(CXLIV) 87.01-99.99 Miscellaneous diagnostic and non-surgical procedures

(iii) ICU/CCU (level 7) and routine (level 8) care are peer grouped based on hospital teaching and nonteaching status. These two levels of care are peer grouped because

a statistically significant difference in cost was found between teaching and nonteaching hospitals in these categories. Therefore, for payment purposes, hospitals that either belong to the Council on Teaching Hospitals or have a medical school affiliation qualify for the teaching peer grouped rate for Levels 7 and 8. All other hospitals shall receive the nonteaching rate for Levels 7 and 8.

(C) **Adjustments.** Level of care per diem rates will be reviewed periodically and adjusted as necessary through a public process.

(3) **Fixed capital per diem.** The second rate component is the per diem capital component. Fixed capital per diem is calculated separately for acute care inpatient hospitals and freestanding inpatient psychiatric hospitals using different methodologies.

(A) **Fixed capital per diem methodology for freestanding psychiatric hospitals.** Inpatient psychiatric hospitals fixed rate capital cost will be reimbursed using the average fixed rate capital cost of all Medicaid enrolled freestanding psychiatric inpatient hospitals from calendar year 1991 cost reports.

(B) **Fixed capital per diem methodology for acute care inpatient hospitals.** Inpatient hospital fixed capital per diem cost will be reimbursed using a peer group fixed capital weighted payment method.

(i) There are five peer groups based on level of care of the services offered:

(I) Teaching hospitals with burn and NICU units.

(II) Teaching hospitals with NICU units, but no burn unit.

(III) Teaching hospitals without NICU or burn unit.

(IV) Non-teaching hospitals with NICU units, but no burn unit.

(V) Non-teaching hospitals with no burn or NICU unit.

(ii) A value factor for each level of care within a peer group is determined by dividing each level of care per diem rate (peer group statewide level of care rate per diem) by the average of all the level of care rates within a peer group.

(iii) The peer group fixed capital per diem weighted payment component for each level of care is then determined by multiplying the statewide median fixed capital of all inpatient hospitals by the level of care value factor derived in (ii) of this subparagraph.

(C) **Adjustments.** The statewide fixed capital per diem average of all freestanding psychiatric hospitals and the statewide fixed capital per diem median of all inpatient hospitals will be reviewed periodically and adjusted as necessary through a public process.

(4) **Disproportionate share hospitals (DSH).**

(A) **Eligibility.** A hospital shall be deemed a disproportionate share hospital, as defined by Section 1923 of the federal Social Security Act, if the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or if the hospital's low-income utilization rate exceeds 25%.

(i) Eligibility for disproportionate share hospital payments will be determined annually by the OHCA before the beginning of each federal fiscal year based on cost and revenue survey data completed by the hospitals. The survey must be received by OHCA each year by April 30. The information used to complete the survey must be extracted from the hospital's financial records and fiscal year cost report ending in the most recently completed calendar year, for entities that meet the Medicare Provider designation (refer to Medicare Program Memorandum No. A-96-7 for requirements). A hospital may not include costs or revenues on the survey which are attributable to services rendered in a separately licensed/certified entity. Hospitals found to be ineligible for disproportionate share status upon audit shall be required to reimburse the Authority for any disproportionate share

payment adjustments paid for the period of ineligibility.

(ii) Beyond meeting either of the tests found in (i) of this subparagraph, there are three additional requirements which are:

(I) Any hospital offering non-emergency obstetrical services must have at least two obstetricians with staff privileges who have agreed to provide services to Medicaid beneficiaries. This requirement does not apply to children's hospitals.

(II) In the case of an urban hospital, a hospital located in an MSA, an "obstetrician" is defined as any board-certified obstetrician with staff privileges who performs non-emergency obstetrical services at the hospital. In the case of a rural hospital, an "obstetrician" is defined to include any physician with staff privileges who performs non-emergency obstetrical services at the hospital.

(III) A hospital must have a Medicaid inpatient utilization rate of at least one percent.

(B) **Payment adjustment.**

(i) Beginning federal fiscal year 1993 and each year thereafter, DSH payment adjustments will be capped by the federal government. Financial participation from the federal government will not be allowed for expenditures exceeding the capped amount. Eligible DSH hospitals will be assigned to one of the three following categories:

(I) public-private acute care teaching hospital which has 150 or more full-time equivalent residents enrolled in approved teaching programs (using the most recently completed annual cost report) and is licensed in the state of Oklahoma. Public-private hospital is a former state operated hospital that has entered into a joint operating agreement with a private hospital system;

(II) other state hospitals; or

(III) private hospitals and all out-of-state hospitals.

(ii) Payment adjustments will be made on a quarterly basis for federal fiscal year 1994 and thereafter using the following formula that determines the hospital's annual allocation:

(I) Step 1. The Medicaid revenue and imputed revenue for charity are totaled for each hospital qualifying for disproportionate share adjustments.

(II) Step 2. A weight is assigned to each qualifying hospital by dividing each hospital's revenue total (Medicaid and charity) by the revenue total of the public-private acute care teaching hospital, which has the assigned weight of 1.0.

(III) Step 3. A weighted value is then determined for each hospital by multiplying the hospital's assigned weight by the hospital's total Medicaid and charity revenue.

(IV) Step 4. The weighted values of all hospitals qualifying for disproportionate share adjustments are totaled.

(V) Step 5. The percentage of the public-private acute care teaching hospital's weighted value is determined in relation to the weighted values of all qualifying disproportionate share hospitals.

(VI) Step 6. The weighted values of all state hospitals (except public-private acute care teaching hospital) are totaled.

(VII) Step 7. The weighted values of all private and out-of-state hospitals qualifying for disproportionate share adjustments are totaled.

(VIII) Step 8. The percentage of the total weighted values of the hospitals included in Step 6 (State hospitals except public-private acute care teaching hospital) is calculated in relation to the total weighted values (sum of Step 6 and 7) of all remaining hospitals qualifying for disproportionate share adjustment.

(IX) Step 9. The percentage of weighted values of the hospitals included in Step 7 (private hospitals and all out-of-state hospitals) is calculated in relation to the total weighted values (sum of Steps 6 and 7) of all remaining hospitals qualifying for disproportionate share adjustment.

(X) Step 10. The weighted percentages for the three hospital groups are next applied to the capped disproportionate share amount allowed by HCFA for the federal fiscal year. The amount of disproportionate share to be paid to the public-private acute care teaching hospital is determined by multiplying the state disproportionate share allotment by the weighted percentage of the public-private acute care teaching hospital. Beginning FFY 96, the weighted percentage amount to be paid will not exceed 82.82%. Payment of disproportionate share funds to public/private hospitals will be made to the public entity that is organizationally responsible for indigent care. The weighted percentage amount is then subtracted from the state disproportionate share allotment. Once the public-private acute care teaching hospital's share of the state disproportionate share allotment has been subtracted, the state hospitals' weighted percentage is applied to the remainder. Beginning FFY 96, the State hospital's weighted percentage (from VIII of this subunit) will not be less than 75.3%. The balance of the disproportionate share allotment is distributed to private hospitals and all out-of-state hospitals. Distribution of funds within each group will be made according to the relationship of each hospital's weighted value to the total weighted value of the group.

(iii) Payment adjustments to individual hospitals will be limited to 100 percent of the hospital's costs of providing services (inpatient and outpatient) to Medicaid recipients and the uninsured, net of payments received from Medicaid (other than DSH) and uninsured patients.

(5) **Critical Access Hospitals.** Critical Access Hospitals (CAHs) are rural public or non-profit hospitals which provide 24 hour emergency care services, are limited to 15 inpatient beds (can have 10 additional swing beds) and inpatient stays are limited

to 96 hours. A payment adjustment will be made to hospitals certified by the Oklahoma State Department of Health as Critical Access Hospitals.

(6) **Indirect medical education (IME) adjustment.**

(A) Effective February 11, 1999, acute care hospitals that qualify as major teaching hospitals will receive an indirect medical education (IME) payment adjustment, which covers the increased operating, or patient care, costs that are associated with approved intern and resident programs.

(B) In order to qualify as a major teaching hospital and be deemed eligible for an IME adjustment, the hospital or hospitals of common ownership must:

(i) belong to the Council on Teaching Hospitals or have a medical school affiliation; and

(ii) be licensed by the State of Oklahoma; and

(iii) have 150 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

(C) Eligibility for an IME adjustment will be determined by the OHCA, using the provider's most recently received annual cost report or the application [see paragraph (7) of this subsection] for the quarterly Direct Medical Education Supplemental payment adjustment.

(D) An annual fixed IME payment pool will be established based on the State matching funds made available by transfers from other State agencies. The pool of funds will be distributed annually each State fiscal year. The total pool of monies made available by funds transferred by any State agency will be limited to $10,038,714, the 1999 base year amount. The base year payment amount will be updated annually each July 1 using the first quarter publication of the DRI PPS-type Hospital market basket forecast for the midpoint of the upcoming fiscal year, if funds are available.

(E) The payments will be distributed equally. For hospitals that have public-private ownership, or have entered into a joint operating agreement, payment will be made to the public entity that is organizationally responsible for the public

teaching mission.

(F) If payment causes total payments to exceed Medicare upper limits as required by 42 CFR 447.272, the payment will be reduced to not exceed the Medicare upper limit.

(7) **Direct medical education supplemental incentive payment adjustment.**

(A) Effective July 1, 1999, in-state hospitals that qualify as teaching hospitals will receive a supplemental payment adjustment for direct medical education (DME) expenses. These payments will be made in order to encourage training in rural hospital and primary care settings and to recognize the loss of support for GME due to the advent of Managed Care capitated programs.

(B) In order to qualify as a teaching hospital and be deemed eligible for DME supplemental incentive payment adjustments, the hospital must:

(i) be licensed by the State of Oklahoma;

(ii) have costs associated with approved or certified Oklahoma medical residency programs in medicine, osteopathic medicine, and associated specialties and sub-specialties. An approved medical residency program is one approved by the Accrediting Council for Graduate Medical Education of the American Medical Association, by the Bureau of Professional Education of the American Osteopathic Association, or other professional accrediting associations. A resident is defined as a Post-Graduate Year 1 (PGY1) and above resident who participates through hospital or hospital-based rotations in approved medical residency/internship programs in Family Medicine, Internal Medicine, Pediatrics, Surgery, Ophthalmology, Psychiatry, Obstetrics/Gynecology, Anesthesiology, Osteopathic medicine, or other Certified Medical Residencies, including specialties and sub-specialties as required in order to become certified by the appropriate board; and

(iii) apply for certification by the OHCA prior to receiving payments for any quarter during a State Fiscal year. To qualify, a hospital must have a contract with the Oklahoma Health Care Authority (OHCA) to provide

Medicaid services and belong to The Council on Teaching Hospitals or otherwise show proof of affiliation with an approved Medical Education Program. Affiliation means an agreement to support the costs of medical residency education in the approved programs.

(iv) Federal and state hospitals, including Veteran=s Administration, Indian Health Service/Tribal and Department of Mental Health Hospitals are not eligible for supplemental DME payments. Major teaching hospitals as defined in (5)(B)(i)(I) of this subsection are eligible.

(C) Determination of a hospital's eligibility for a DME supplemental payment adjustment will be done quarterly by the OHCA based on reports designed by the OHCA. The reports will detail the resident-months of support provided by the hospital and the total eligible Medicaid days of service from the paid claims for the same quarter and be attested to by the hospital Administrator, or designated personnel. The annual application must be attested to by the hospital administrator and by the residency program director. All reports will be subject to audit and payments will be recouped for inaccurate or false data. The amount of resident-months will also be compared to the annual budgets of the schools, the annual HCFA form 2552 (Cost Report) and the monthly assignment schedules.

(D) An annual fixed DME payment pool will be established based on the State Matching funds made available by the University Hospitals Authority or other State agencies.

(E) The payments will be distributed based on the relative value of the weighted resident-months at each participating hospital. A resident-month is defined as a PGY1 and above resident full-time equivalent (FTE) for that month. Resident is defined in (B)(ii) of this paragraph. An FTE is defined as a resident assigned by the residency program to a rotation that is hospital or hospital-based. The resident must be assigned to a specific hospital for a supervised hospital-based residency experience. Required residency clinical or educational experience will be allowed. The time residents spend in non-provider settings such as freestanding clinics, nursing homes and physicians' offices in connection with approved programs may be included in determining the number of FTE's in the count if the following conditions are met:

(i) The resident spends his or her time in patient care activities.

(ii) The written agreement between the hospital and the non-hospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the non-hospital site and the hospital is providing reasonable compensation to the non-hospital site for supervisory teaching activities.

(iii) The hospital must incur all or substantially all of the costs for the training program in the non-hospital setting, which means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians= salaries and fringe benefits attributable to direct graduate medical education.

(F) Training outside the formal residency program (moonlighting) is not eligible for this payment. The pool of available funds will be distributed quarterly based on the relative value of the eligible hospitals' resident-months weighted for Medicaid services rendered.

(i) The weighted relative value is determined as follows:

(I) Annually (prior to each state fiscal year) the OHCA will determine each participating hospital's individual acuity factor from data taken from the Oklahoma MMIS system (or reported claims data) by using the days of services and weights determined for the levels of care.

(II) Determine the total resident-months from the quarterly reports in (7)(C) of this subsection for each hospital.

(III) Determine the total eligible patient days for the quarter from the quarterly reports in (7)(C) of this subsection for each hospital reporting.

(IV) Determine the relative value for each hospital. The relative value is defined as the product of the individual acuity factor [see (I) of this unit] times

the total resident-months [see (II) of this unit] times the eligible patient days [see III of this unit].

(ii) The pool of available funds will be allocated quarterly based on the prior quarter=s relative value as determined in (i)(IV) of this subparagraph. The per resident-month amount will be limited to $11,000 and the total payments will be limited to and not exceed the upper payment limits described in (G) of this paragraph.

(G) If payment in (D) of this paragraph causes total payments to exceed Medicare upper limits as required by CFR 447.272, the payment will be reduced to not exceed the Medicare upper limit.

(8) **Non-State Public Hospital Payment Adjustment.** Effective July 1, 2002, all Oklahoma non-state publicly owned hospitals (i.e., City, County or Title 60 Trust hospitals within the state of Oklahoma that are neither owned nor operated by the state of Oklahoma) shall qualify for a public hospital rate adjustment. The adjustment shall be equal to each eligible hospitals=s pro rata share of a funding pool, based on the hospital=s Medicaid utilization in the base year. The amount of the total pool will not be in excess of the aggregate Medicare-related upper payment limit. The amount of the funding pool shall be determined by OHCA annually as follows:

(A) Using data from the most recently completed cost reports and Medicaid Management Information System data, the OHCA shall determine each non-state publicly owned hospital=s Medicaid cost (using Medicare allowable cost reimbursement principles) and Medicaid payments.

(B) The base Medicaid cost will be trended forward using an annual DRI PPS-type hospital market basket index. Base year Medicaid payments will be trended by applicable updates to the payment rates.

(C) Once the Medicaid costs have been trended forward, the base Medicaid payments will be subtracted from the allowable costs. This difference for each hospital is their portion of the total available funding pool.

(D) The amount of each eligible hospital's payment adjustment shall be its pro rata percentage multiplied by the amount of

the funding pool.

(E) Payment will be made on a quarterly basis.

(9) **Transplants.** In addition to the normal level of care per diem rate, an additional reimbursement amount may be negotiated, subject to the availability of services. The negotiated rate for the inpatient hospital charges associated with the transplant surgery shall not exceed 75 percent of the billed charges with a maximum payment of $150,000.

(10) **Prosthetic devices.** Payment for prosthetic devices implanted during surgery is included within the level of care per diem rates except for: Cochlear Implants, Vagus Nerve Stimulator, and implantable medication pumps. Additional payment will be considered on a case by case basis. A prior authorization from the Medical Professional Services Unit of the OHCA will be required.

(11) **Out-of-state hospitals.**

(A) Out-of-state hospitals, for which the Authority has on file a fiscal year 1989 or more recent cost report, shall be reimbursed as follows:

(i) the level of care per diem rate

(ii) a fixed capital per diem

(iii) a hospital-specific per diem direct medical education rate.

(B) Hospitals, for which the Authority does not have a fiscal year 1989 or more recent cost report on file, will also receive the level of care per diem rates; however, capital and direct medical education rate components will not be reimbursed on a hospital-specific basis. Instead, these hospitals shall receive the statewide median capital per diem amount. The statewide median direct medical education per diem rate will be paid to qualifying hospitals.

(C) In the absence of substantiating information verifying eligibility for the teaching hospital peer group, an out-of-state hospital will be presumed to be a non-teaching hospital and will be paid at the non-teaching rate for levels 7 and 8.

(D) In the absence of substantiating information verifying the presence of a burn unit or a level III NICU, an out-of-state hospital will be presumed to be ineligible for burn and NICU level of care payments.

(E) Out-of-state hospitals shall submit to the Authority the following documentation (as appropriate):

(i) Substantiating information verifying qualification as a teaching hospital

(ii) Substantiating information verifying presence of a burn unit

(iii) Substantiating information verifying presence of a NICU that meets Level III criteria established by the Health Planning Commission (now part of the Oklahoma Department of Health) in its 1988 Hospital Utilization and Plan Survey.

317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covere-d as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six covered prescriptions per month with a limit of three brand name prescriptions.

(2) Subject to the limitations set forth in OAC 317:30-5-72.1, OAC 317:30-5-77.2, and OAC 317:30-5-77.3, exceptions to the six medically necessary prescriptions per month limit are:

(A) Unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded; and

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

(3) Drugs exempt from the prescription limit include: Antineoplastics, anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV), certain prescriptions that require frequent laboratory monitoring, birth control prescriptions, over the counter contraceptives, hemophilia drugs, compensable smoking cessation products, low-phenylalanine formula and amino acid bars for persons with a diagnosis of PKU, certain solutions used in compounds (i.e. sodium chloride, sterile water, etc.), and drugs used for the treatment of tuberculosis. For purposes of this Section, exclusion from the prescription limit means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month.

(b) **Coverage for children.** Prescription drugs for Medicaid eligible individuals under 21 years of age are not limited.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are eligible for a prescription drug benefit.

317:30-5-72.1. Drug benefit

OHCA administers and maintains an Open Formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The Authority covers any drug for its approved purpose that has been approved by the Food and Drug Administration (FDA) for manufacturers who have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA) subject to the following exclusions, and limitations.

(1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:

(A) Agents used to promote fertility.

(B) Agents primarily used to promote hair growth.

(C) Agents used for cosmetic purposes.

(D) Agents used for the symptomatic relief of coughs and colds. Cough and cold drugs are not covered.

(E) Vitamins and Minerals.

(F) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.

(G) Agents used for smoking cessation. Nicotine replacement products are not covered.

(H) Food supplements.

(I) Agents that are experimental or whose side effects make usage controversial.

(J) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

(K) Over-the-counter drugs. Over-the-counter medications are

not covered except for those medications listed in Paragraph (3) of this subsection.

(2) The exceptions to the exclusions provided in subsection OAC 317:30-5-72.1(1) are as follows:

(A) Agents used for the systematic relief of cough and colds. Antihistamines for allergies or antihistamine use associated with asthmatic conditions may be covered when medically necessary and prior authorized.

(B) Vitamins and Minerals. Vitamins and minerals are not covered except under the following conditions:

(i) prenatal vitamins are covered for pregnant women up to age 50;

(ii) fluoride preparations are covered for persons under 16 years of age or pregnant; and

(iii) calcifediol/calciferol when used to treat end stage renal disease are covered.

(C) Agents used primarily for the treatment of anorexia or weight gain. There is limited coverage under the scope based prior authorization.

(D) Agents used for smoking cessation. A limited smoking cessation benefit is available through OAC 317:30-5-77.2(e)(1)(B)(ii).

(E) Over the counter drugs. Insulin, PKU formula and amino acid bars, certain smoking cessation products, and the following family planning products are covered.

(i) Male and Female Condoms.

(ii) Contraceptive sponges.

(iii) Diaphragms.

(iv) Spermicidal jellies, creams, suppositories, and foams.

(3) All covered outpatient drugs are subject to prior

authorization as provided in OAC 317-30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

(A) the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. ' 1396r-8;

(B) the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and the Health Care Financing Administration;

(C) OHCA has excluded coverage of the drug from its formulary established by the State as provided under 42 U.S.C. ' 1396r-8.

317:30-5-77.1. Dispensing Quantity

(a) Prescription quantities are to be limited to a 34 day supply except in the following situations:

(1) The Drug Utilization Review Board has recommended a different day supply or quantity limit based on published medical data, including the manufacturer's package insert, provided the Chief Executive Officer of the OHCA has approved the recommendation;

(2) The product is included on the Maintenance List of medications which are exempt from this limit and may be dispensed up to 100 units;

(3) The manufacturer of the drug recommends a dispensing quantity less than a 34 day supply;

(b) Refills are to be provided only if authorized by the prescriber, allowed by law, and should be in accordance with the best medical and pharmacological practices.

(c) The Drug Utilization Review Board shall develop a Maintenance List of medications which are used in general practice on a continuing basis. These drugs shall be made available through the vendor drug program in quantities up to 100 units when approved by the prescriber. The Drug Utilization Review Board shall review the Maintenance List at least annually. The Maintenance List shall be approved by the Chief Executive Officer of OHCA. When approved by the prescriber, all maintenance medications must be filled at the maximum quantity allowed after a sufficient stabilization period when dispensed to Medicaid clients who do not reside in a long term care facility. For clients residing in a long term care facility, chronic medications, including all products on the Maintenance List, must be dispensed in quantities of not less than a 28 day supply.

(d) For products covered by the Oklahoma Vendor Drug Program the metric quantity shown on the claim form must be in agreement with the descriptive unit of measure applicable to the specific NDC. Only numeric characters should be entered. Designations, such as the form of drug, i.e., Tabs, Caps, Suppositories, etc., must not be used. Products should be billed in a manner consistent with quantity measurements.

317:30-5-77.2. Prior authorization

(a) **Definition**. The term prior authorization means an approval for payment by OHCA to the pharmacist before a prescription is dispensed by the pharmacist.

(b) **Process**. Because of the required interaction between a prescribing provider (such as a physician) and a pharmacist to receive a prior authorization, OHCA allows a pharmacist up to a 30 calendar day period from the point of sale notification to provide the data necessary for OHCA to make a decision regarding prior authorization. Should a pharmacist fill a prescription prior to the actual authorization he/she takes a business risk that the claim for filling the prescription will be denied. In the case that information regarding the prior authorization is not provided within the 30 day calendar period, claims will be denied.

(c) **Documentation.** OHCA administers a prior authorization program through a contract with an agent. Prior Authorization requests with clinical exceptions must be mailed or faxed to the Medication Authorization unit of the agent. Other authorization requests, claims processing questions and questions pertaining to DUR alerts must be addressed by contacting the Pharmacy help desk. Authorization requests with complete information are reviewed and a response returned to the dispensing pharmacy within 24 hours.

(d) **Emergencies.** In an emergency situation the Health Care Authority will authorize a 72 hour supply of medications to a client. The authorization for a 72 hour emergency supply of medications does not count against the Medicaid limit described in OAC 317:30-5-72(a)(1).

(e) **Utilization and scope.** There are three reasons for the use of prior authorization: utilization controls, product based controls, and scope controls. Scope controls refer to constraints used to insure a drug is used for approved indications and is therapeutically appropriate.

(1) **Utilization.**

(A) **Quantity.** Toradol is covered for eligible individuals for a quantity up to 22 tablets or a 5 day supply whichever is less, each month. Prior authorization is required when additional coverage is medically necessary beyond this limit.

(B) **Duration.**

(i) **Smoking cessation products.** A 90-day smoking cessation benefit consisting of Zyban, prescription or non-prescription nicotine replacement products, or Zyban/nicotine replacement combination is covered once per twelve months. Coverage beyond 90 days requires prior authorization and proof of enrollment in a behavior modification program, such as the Oklahoma Tobacco Helpline or a manufacturer's telephone counseling program.

(ii) **Benzodiazepines and barbiturates.** Selected Barbiturates and Benzodiazepines are covered for eligible individuals for 90 days of therapy in the previous 360 days. Prior authorization is required for other medications in this category and when additional coverage is medically necessary beyond this limit.

(iii) **Hypnotics.** Hypnotic medications are covered for eligible individuals for 90 days of therapy in the previous 360 days. Prior authorization is required when additional coverage is medically necessary beyond this limit.

(2) **Scope**.

(A) **Antihistamines.** Legend antihistamines are covered only after a previous trial with an over-the-counter antihistamine. Over-the-counter non-sedating antihistamines are a covered benefit for children under 21 years of age. The trial should be with an antihistamine that exhibits comparable characteristics to the legend alternative. Also, the trial should have been in the last month and be of adequate dose and duration. A fourteen day trial of an over-the-counter non-sedating antihistamine is required prior to approval of a legend product for all clients.

(B) **Growth Hormone.** Growth Hormone is a covered medication via the prior authorization program provided the patient meets the applicable criteria for initiation and continuance of treatment. The following are the specific indications in which growth hormone therapy will be considered for coverage:

(i) the treatment of short stature, Turner=s syndrome, hypoglycemia related growth hormone deficiency;

(ii) physiologic replacement for adults who previously met growth hormone deficiency guidelines as children; and

(iii) catabolic wasting in AIDS patients.

(C) **Anorexiants.** Limited anorexiant coverage is available for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) and Narcolepsy through Product Based Prior Authorization.

(D) **TB related medications.** Certain drugs prescribed for the treatment of TB related morbidities require prior authorization.

(E) **Clopidigrel (PlavixJ).** Clodpidigrel is covered for eligible individuals through the prior authorization process. Authorization will be granted to individuals with diagnoses for which an approved indication exists and the individual has a contra-indication for aspirin use or has a therapeutic failure with previous aspirin therapy.

(F) **Multiple indication medications.** Medications which have been approved by the FDA for multiple indications may be subject to a scope-based prior authorization when at least one of the approved indications places that drug into a therapeutic category or treatment class for which a prior authorization is required. Prior authorizations for these drugs may be structured as step therapy or a tiered approach as recommended by the Drug Utilization Review Board and approved by the OHCA Board of Directors.

(G) Prior authorization may be required to assure compliance with FDA approved and/or medically accepted indications, dosage, duration of therapy, quantity, or other appropriate use criteria including pharmacoeconomic consideration.

317:30-5-198. Coverage by category

(a) **Adults.** There is no coverage for services rendered to adults.

(b) **Individuals eligible for Part B of Medicare.** EPSDT Center services provided to Medicare eligible recipients should be billed directly to the fiscal agent.

(c) **Children.** Payment is made for compensable services rendered in eligible child health centers as described below:

(1) **Child health screening examination.** An initial screening may be requested by an eligible individual at any time and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. A child health screening examination must include all of the following components to be compensable.

(A) **Comprehensive health and development history.** This information may be obtained from the parent or other responsible adult who is familiar with the child's history and include an assessment of both physical and mental health development. Coupled with the physical examination, this includes:

(i) **Developmental Assessment.** The developmental assessment includes a range of activities to determine whether an individual's developmental processes fall within a normal range of achievement according to age group and cultural background. Screening for developmental assessment is a part of every routine, initial and periodic screening examination. Providers should acquire information on the child's usual functioning as reported by the child, teacher, health professional or other familiar person and review developmental progress as a component of overall health and well-being given the child's age and culture. As appropriate, assess the following elements:

(I) Gross and fine motor development;

(II) Communication skills, language and speech development;

(III) Self-help, self-care skills;

(IV) Social-emotional development;

(V) Cognitive skills;

(VI) Visual-motor skills;

(VII) Learning disabilities;

(VIII) Psychological/psychiatric problems;

(IX) Peer relations; and/or

(X) Vocational skills.

(ii) **Assessment of Nutritional Status.** Nutritional assessment may include preventive treatment and follow-up services including dietary counseling and nutrition education if appropriate. This is accomplished in the basic examination through:

(I) Questions about dietary practices;

(II) Complete physical examination, including an oral dental examination;

(III) Height and weight measurements;

(IV) Laboratory test for iron deficiency; and

(V) Serum cholesterol screening, if feasible and appropriate.

(B) **Comprehensive unclothed physical examination.** A comprehensive unclothed physical examination includes the following:

(i) **Physical growth.** Record and compare height and weight with those considered normal for that age; record head circumference for children under one year of age; and report height and weight over time on a graphic recording sheet.

(ii) **Unclothed physical inspection.** Check the general appearance of the child to determine overall health status and detect obvious physical defects. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal.

(C) **Appropriate immunizations.** Assess whether the child has been immunized against diphtheria, pertussis, tetanus, polio, measles, rubella, and mumps, and whether booster shots are needed. Immunizations must be provided when medically necessary and appropriate. Immunizations can be provided at the time of the screening when appropriate. Separate payment will be made for immunizations which are given at the time of the screening.

(D) **Appropriate laboratory tests.** Use medical judgement in determining the applicability of the laboratory tests or analyses that are medically contraindicated at the time of the screening, provide them when no longer medically contraindicated. Laboratory tests should only be given when medical judgement determines they are appropriate. However, laboratory tests should not be routinely administered. As appropriate, conduct the following laboratory tests:

(i)Lead toxicity screening. Is required for every Medicaid eligible child at 12 and 24 months of age. A lead toxicity screening is also required for any Medicaid eligible child 36 to 72 months of age who has not previously been screened for lead poisoning. Any additional lead toxicity screening will continue to be covered based on a provider=s medical judgment.

(ii) Anemia test.

(iii) Sickle cell test. If a child has been properly tested once for sickle cell disease, the test need not be repeated.

(iv) Tuberculin test. Give a tuberculin test to every child who has not received one within a year.

(v) In addition to the tests listed (i) through (iv) of this subparagraph, there are several other tests to consider. Appropriateness is determined by an individual's age, sex, health history, clinical symptoms

and exposure to disease. These may include a urine screening, pinworm slide, urine culture (for girls), serological test, drug dependency screening, stool specimen for parasites, ova, blood and HIV screening.

(E) **Health Education.** Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental assessment, or screening, gives the initial context for providing health education. Health education and counseling to both parents, guardians or children is required. It is designed to assist in understanding expectations of the child's development and provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

(F) **Vision and hearing screens.** Vision and hearing services are subject to their own periodicity schedules. However, age appropriate vision and hearing assessments must be performed as a part of the screening.

(G) **Dental screening services.** An oral dental examination may be included in the screening and as a part of the nutritional status assessment. Federal regulations require a direct dental referral for every child in accordance with the periodicity schedule and at other intervals as medically necessary. Therefore, when an oral examination is done at the time of the screening, the child may be referred directly to a dentist for further screening and/or treatment.

(H) **Diagnosis and treatment.** When a screening indicates the need for further evaluation of an individual's health, a referral for diagnostic services are defined as those services necessary to fully evaluate defects, physical or mental illnesses or conditions discovered by the screening.

(I) **Other.** Health care, treatment, or other measures to correct or ameliorate defects, physical or mental illnesses or conditions must also be provided and will be covered by the EPSDT Program. The defects, illnesses and conditions must have been discovered during the screening or shown to have increased in severity.

(J) **Services deemed medically necessary.** Services deemed medically necessary and allowable under federal Medicaid

regulations, may be covered by the EPSDT Program even though those services may not be part of the Oklahoma Health Care Authority Medicaid program. However, such services must be prior authorized and must be allowable under federal Medicaid regulations. Federal Medicaid regulations also require the state to make the determination as to whether the service is necessary and do not require the provision of any items or services that the state determines are not safe and effective or which are considered experimental.

(2) **Dental screening examination.** An examination for dental disease by an Oklahoma licensed dentist. This will include prophylaxis with fluoride treatment, and charting of needed treatment and, if necessary, x-rays (including two bite wing films).

(3) **Dental sealants.** Professional application of dental sealants when appropriate to prevent pit and fissure caries requires prior authorization. Provider warrants this service to OHCA for a period of eight years, replacement of lost sealants will be at no cost to OHCA. Teeth numbers 03, 14, 19 and 30 are eligible for sealants from eruptions thru eight years of age. Teeth numbers 02, 15, 18 and 31 from eruption thru 13 years of age. Teeth numbers 04, 05, 12, 13, 20, 21 and 29 from eruption thru 14 years of age.

(4) **Dental services.** At a minimum, dental services include relief of pain and infection; restoration of teeth and maintenance of dental health; and/or oral prophylaxis one each 12 months. Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures. Other dental services include inpatient services in an eligible participating hospital, amalgam and composite restorations, pulpotomies, chrome steel crowns, anterior root canals, pulpectomies, band and loop space maintainers, cement basis, acrylic flippers and lingual arch bars; other restoration, repair and/or replacement of dental defects. Some services may require prior authorization. Services are to be provided as referenced in OAC 317:30-5, Part 79 (Dentists).

(5) **Child health encounter.** The child health encounter may include a diagnosis and treatment encounter, a follow-up health

encounter, or a home visit. A Child Health Encounter may include a child health history, physical examination, developmental assessment, nutrition assessment and counseling, social assessment and counseling, genetic evaluation and counseling, indicated laboratory and screening tests, screening for appropriate immunizations, health counseling and treatment of childhood illness and conditions.

(6) **Child health diagnosis encounter.** The child health diagnosis encounter consists of the following procedures:

(A) an intake process and diagnosis interview which reviews the relevant developmental, medical, genetic, psychosocial, educational, and behavioral history;

(B) clinical observations and standardized assessment procedures regarding the client's overall development including emotional, speech, language, or hearing abilities;

(C) feedback regarding evaluation results which is provided to appropriate family and/or collaterals; and

(D) development of a treatment plan.

(7) **Child guidance treatment encounter.** A child guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children who are identified as having specific disorders or delays in development, emotional, or behavioral problems, or disorders of speech, language or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of a treatment plan.

(8) **Immunization.** Immunizations will include all appropriate immunizations given in connection with a Child Health Screening Examination or Child Health Encounter.

(9) **Multidisciplinary review.** Multidisciplinary review of the treatment plan in order to determine if services should be continued, modified or terminated as evidenced by services rendered in child health and child guidance programs.

(10) **Hearing evaluation.** Hearing evaluation includes pure tone air, bone and speech audiometry provided by a state licensed

speech pathologist or audiologist who:

(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(11) **Audiometry test.** Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state licensed speech pathologist or audiologist who:

(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(12) **Ear impression (for earmold).** Ear impression (for earmold) includes taking impression of a client's ear and providing a finished earmold which is used with the client's hearing aid provided by a state licensed speech pathologist or audiologist who:

(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

317:35-5-25. Citizenship requirements

(a) **Establishment of citizenship and alienage.** Medicaid services are provided to the defined groups provided in this subsection if they meet all other factors of eligibility.

(1) **U.S. Citizens and aliens admitted for permanent residence.** The groups listed in the following subparagraphs are eligible for the full range of Medicaid services.

(A) U.S. Citizens;

(B) aliens admitted for permanent residence who have resided in the United States for a period greater than five years from the date of entry; and

(C) certain parolees, refugees, Western Hemisphere aliens, immigrants, conditioned entries, Kickapoo Indians and American Indians born in Canada.

(2) **Eligible aliens (qualified aliens).** The groups listed in the following subparagraphs are eligible for the full range of Medicaid services. A qualified alien is:

(A) an alien who was admitted to the United States and has resided in the United States for a period greater than five years from the date of entry and who was:

(i) lawfully admitted for permanent residence under the Immigration and Nationality Act;

(ii) paroled into the United States under Section 212(d)(5) of such Act for a period of at least one year;

(iii) granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to April 1, 1980; or

(iv) a battered spouse, battered child, or parent or child of a battered person with a petition under 204(a)(1)(A) or (B) or 244(a)(3) of the Immigration and Naturalization Act.

(B) an alien who was admitted to the United States and who

was:

(i) granted asylum under Section 208 of such Act regardless of the date asylum is granted;

(ii) a refugee admitted to the United States under Section 207 of such Act regardless of the date admitted;

(iii) an alien with deportation withheld under Section 243(h) of such Act regardless of the date deportation was withheld;

(iv) a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980, regardless of the date of entry;

(v) an alien who is a veteran as defined in 38 U.S.C. ' 101, with a discharge characterized as an honorable discharge and not on the grounds of alienage;

(vi) an alien who is on active duty, other than active duty for training, in the Armed Forces of the United States;

(vii) the spouse or unmarried dependent child of an individual described in (C) or (D) of this subsection.

(viii) a victim of a severe form of trafficking pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000; or

(ix) admitted as an Amerasian immigrant.

(C) permanent residents who first entered the country under (2)(B) of this subsection and who later converted to lawful permanent residence status.

(3) **Other aliens lawfully admitted for permanent residence (non-qualified aliens).** Non-qualified aliens are those individuals who were admitted to the United States and who do not meet any of the definitions in (1)-(2) of this subsection. Non-qualified aliens are ineligible for Medicaid for five years from the date of entry except that non-qualified aliens are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute

symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention.

(4) **Illegal aliens.** Illegal aliens who do not meet any of the definitions in (1)-(2) of this subsection are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention.

(5) **Ineligible aliens.** Ineligible aliens who do not fall into the categories in (1)-(4) of this subsection, yet have been lawfully admitted for temporary or specified periods of time include, but are not limited to: foreign students, visitors, foreign government representatives, crewmen, members of foreign media and temporary workers including agricultural contract workers. This group is ineligible for Medicaid, including emergency services, because of the temporary nature of their admission status. ■ 1

(6) **Declaration.** A declaration of citizenship/alien status is required for all adults and children approved for Medicaid. This requirement is met when all adults in the case or person acting in behalf of individual(s) in the case have signed the application form attesting to the status indicated for all case members on the application form. Persons determined as having lawful alien status must have the status verified through Systematic Alien Verification for Entitlements (SAVE).

(7) **Preauthorization.** Preauthorization is required for payment of emergency medical services rendered to non-qualified and illegal aliens. ■ 2

(b) **Citizenship.** An individual may be a citizen of the United States by being born in the United States or by being born in some other country but moving to the United States and being granted United States citizenship through the Bureau of Citizenship and Immigration Services (BCIS). The area defined by Medicaid regulations pertaining to United States citizenship include the 50 states, the District of Columbia, Puerto Rico, Guam, Virgin Islands

and the Northern Marianas. Nationals from American Samoa or Swain's Island are also regarded as U.S. citizens for Medicaid purposes.

(1) When the situation indicates a need to verify citizenship, birth in the United States may be verified by a birth certificate, religious or similar proof of birth, or a United States passport.

(2) If the individual's birth occurred in some other country and he/she entered the United States as an alien but has become a United States citizen, this must be verified by a certificate of citizenship or certificate of naturalization provided by BCIS.

(3) If the Social Security Administration has already determined the individual meets the citizenship and alienage requirement for SSI or Medicare eligibility, DHS accepts this determination. In such an instance, the individual's notification of eligibility for SSI, SSI check, or Medicare card must be seen and an entry made in the FACS Case Notes as to which of these documents was seen as verification.

(4) In all other instances in which the adult (or a parent of a minor) was an alien who has become a naturalized citizen of the United States, the citizenship papers of the individual must be seen and the exact name shown and any pertinent numbers, dates, etc., must be recorded in the FACS Case Notes.

(c) **Alienage.** A decision regarding eligibility cannot be made until the eligibility condition of citizenship and alienage is determined.

(1) **Immigrants.** Aliens lawfully admitted for permanent residence in the United States are classified as immigrants by the BCIS. These are individuals who entered this country with the express intention of residing here permanently. ■ 3

(2) **Parolees.** Under Section 212(d)(5) of the Immigration and Nationality Act, individuals can be paroled into the United States for an indefinite or temporary period at the discretion of the United States Attorney General. Individuals admitted as Parolees are considered to meet the "citizenship and alienage" requirement. ■ 4

(3) **Refugees and Western Hemisphere aliens.** Under Section 203(a)(7) of the Immigration and Nationality Act, Refugees and Western Hemisphere aliens may be lawfully admitted to the United States if, because of persecution or fear of prosecution due to race, religion, or political opinion, they have fled from a Communist or Communist-dominated country or from the area of the Middle East; or if they are refugees from natural catastrophes. O5 These entries meet the citizenship and alienage requirement. Western Hemisphere aliens will meet the citizenship requirement for Medicaid if they can provide either of the documents in subparagraphs (A) and (B) of this paragraph as proof of their alien status.

(A) Form I-94 endorsed "Voluntary Departure Granted-Employment Authorized", or

(B) The following court-ordered notice sent by BCIS to each of those individuals permitted to remain in the United States: "Due to a Court Order in Silva vs. Levi, 76 C4268 entered by District Judge John F. Grady in the District Court for the Northern District of Illinois, we are taking no action on your case. This means that you are permitted to remain in the United States without threat of deportation or expulsion until further notice. Your employment in the United States is authorized".

(4) **Conditioned entries of aliens made available by the U.S. Attorney General for emergent reasons or for reasons deemed strictly in the public interest.** Conditioned entries of aliens may be made available by the U.S. Attorney General for emergent reasons or for reasons deemed strictly in the public interest. Because the reasons for conditioned entries differ, a decision regarding eligibility can not be made until clearance is received from BCIS.

(5) **Special provisions relating to Kickapoo Indians.** Kickapoo Indians migrating between Mexico and the United States carry Form I-94, Arrival-Departure Record (Parole Edition). If Form I-94 carries the statement that the Kickapoo is "paroled pursuant to Section 212(d)(5) of the Immigration and Nationality Act" or that the "Kickapoo status is pending clarification of status by Congress" regardless of whether such statements are preprinted or handwritten and regardless of a specific mention of the "treaty", they meet the "citizenship and alienage"

requirement. All Kickapoo Indians paroled in the United States must renew their paroled status each year at any local Immigration Office. There are other Kickapoos who have entered the United States from Mexico who carry Form I-151 or Form I-551, Alien Registration Receipt Cards. These individuals have the same status as other individuals who have been issued Form I-151 or Form I-551 and therefore, meet the citizenship and alienage requirements. Still other Kickapoos are classified as Mexican Nationals by the BCIS. They carry Form I-94, Arrival-Departure Record, which has been issued as a visiting visa and does not make mention of the treaty. Such form does not meet the "citizenship and alienage" requirements but provides only the non-immigrant status described in (c)(1) of this Section.

(6) **American Indians born in Canada.** An American Indian born in Canada, who has maintained residence in the United States since entry, is considered to be lawfully admitted for permanent residence if he/she is of at least one-half American Indian blood. This does not include the non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50 percent or more Indian blood. The methods of documentation are birth or baptismal certificate issued on a reservation, tribal records, letter from the Canadian Department of Indian Affairs, or school records.

INSTRUCTIONS TO STAFF

1. **These individuals are generally issued Form I-94, Arrival Departure Record, on which an expiration date is entered. (This form is not the same Form I-94 that is issued to persons who have been paroled into the United States. Parolees carry a Form I-94 that is titled "Arrival-Departure Record - Parole Edition" [see (c)(2) of this Section]. Two other forms that do not give the individual "Immigrant" [see (c)(1) of this Section] status are Form I-186, Nonresident Alien Mexican Border Crossing Card, and Form SW-434, Mexican Border Visitors Permit].**

2. **If the medical service is for labor and delivery, preauthorization is not required. A Recipient On Review Sheet, form MA-13, covering the month(s) of hospitalization must be submitted to the OHCA, Medical Authorization Unit.**

   For emergency services, other than labor and delivery, all other eligibility factors must be determined. Prior to the case being

certified, Form MS-MA-5 is forwarded to the OHCA, Medical Authorization Unit, with "Preauthorization Required (Type) Alien" marked in red at the top.
The case is certified or denied after the preauthorization decision is received from OHCA. The certification period for these cases based on preauthorized medical services is for the month(s) of service only. Due to the variable Medicaid coverage for the groups defined in this subsection, identifying the group with complete documentation and/or verification of appropriate proof of status and identification of the group is recorded in the FACS Case Notes.

3. Acceptable proof of immigration status is Form I-151 or Form I-551, Alien Registration Receipt Cards. Earlier versions of this form, AR-3A, Alien Registration Receipt Card, and AR-3, which carries the same name, are proof of permanent residency if specifically endorsed as such. Also, a Reentry Permit is acceptable proof inasmuch as permanent residency is a requirement of its issuance. Possession of any of these cards verifies that the individual meets the citizenship and alienage requirement.

   An individual who comes to the United States after marriage to, or to marry, a member of the armed forces of the United States would have been admitted with the right of permanent residence and should have the necessary papers to show this status. Subsequent divorce would not affect this right, even though he/she has not become a citizen in his/her own right, and would meet the citizenship and alienage requirement. See DHS Appendix J, Citizenship and Alienage Verification.

4. Individuals in this category should have Form I-94, Arrival-Departure Record, which identifies by stamped information that the alien has been paroled pursuant to Section 212 (d)(5) of the Immigration and Nationality Act. The FACS Case Notes must include a statement that the form identifies the individual as a parolee on Form I-94. See DHS Appendix J, Citizenship and Alienage Verification.

5. Verification of the individual's entry under this section of the law is made by seeing his/her Form I-94, Arrival-Departure Record, which contains stamped information to the effect that

the individual was paroled into the United States indefinitely (no expiration date) as a refugee and specifies the country from which he/she is a refugee.

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

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

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

(2) Capital resources are evaluated on a monthly basis in determining eligibility for an applicant for medical services. An applicant is determined ineligible for any month resources exceed the resource standard at any time during that month. When a recipient 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) Household equipment used for daily living is not considered a resource.

(5) Each time that need is determined, gross income and the equity of each capital resource are established. Equity equals current market value minus indebtedness. The recipient 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 client can convert for current use (no legal impediment involved) are considered as countable resources. Examples of legal impediments include, but are not limited to, clearing an estate, probate, petition to sell or appointment of legal guardian.

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

(2) If a determination is made and documented that the cost of making a resource available exceeds the gain, the client 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 outlines in OAC 317:35-5-41(c)(6). Property has a value regardless of whether there is an actual offer to purchase. Verification of home/real property value is established by collateral contacts with specialized individuals knowledgeable in the type and location of property being considered.

(1) The home may be retained without affecting eligibility

during periods when it is necessary to be absent for illness or other necessity. The OHCA has not set a definite time limit to the client's absence from the home. When it is determined that the client does not have a feasible plan for and cannot be expected to return to his/her home, the market value of the property is considered in relation to the reserve. The client is responsible for taking all steps necessary to convert the resource for use in meeting current needs. If the client is making an effort to make the resource available, a reasonable period of time is given (not to exceed 90 days) to convert the resource. He/she is advised in writing that the 90-day period begins with the determination that the property be considered in relation to the reserve. The 90-day period is given only if efforts are in progress to make the resource available. Any extension beyond the initial 90-day period is justified only after interviewing the client, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the client. A written notification is also provided to the client at any time an extension is allowed. Detailed documentation in the case record is required.

(2) If the client fails or is unwilling to take steps necessary to convert the resource for use in meeting current needs, continuing eligibility cannot be established and the client 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 recipient sells his/her home with the intention of purchasing another home or when an insurance payment for damage to the home is received, a reasonable period of time is given to reinvest the money in another home. A reasonable period of time is considered to be not in excess of a 90-day period. Extensions beyond the 90 days may be justified only after interviewing the client, determining that a good faith effort is still being made and that completion of the transaction is beyond his/her control. This must be documented in the case record.

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

assistance.

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

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

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

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

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

(ii) after 12 months of nursing care, it is assumed there is no reasonable expectation the recipient will be

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

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

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

(E) A client 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, halfsister, halfbrother, 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 salability of mineral rights fluctuate, the establishment of the value of mineral rights are established based on the opinion of collateral sources. Actual offers of

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

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

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

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

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

(11) Homestead rights held by a client in real estate provide the client with shelter (or shelter and income) so long as he/she resides on the property. Payment for care in a nursing facility provided to the recipient through Medicaid constitutes a waiver of the homestead rights of the recipient. If the client moves from the property, a lien is filed, or the client 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, woodcutting tools, mechanized equipment for gardening, livestock grown for home consumption, etc.

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

(A) Checking accounts may or may not represent savings. Current bank statements are evaluated with the client 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 client and a non-recipient person are considered available to the client in their entirety unless it can be established what part of the account actually belongs to each of the owners and the money is actually separated and the joint account dissolved. When the recipient is in a nursing facility and the spouse is in the home or if both are institutionalized, a joint bank account may be maintained with one-half of the account considered available to each.

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

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

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

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

(D) Dividends which accrue and which remain with the insurance company increase the amount of reserve. Dividends which are paid to the client 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 gravesites, crypts, mausoleums, urns, and other repositories which are customarily and traditionally used for the remains of deceased persons. "Immediate family" means individual's minor and adult children, including adopted children and step-children; and individual's brothers, sisters, parents, adoptive parents, and the spouse of these individuals. Neither dependency nor living in the same household will be a factor in determining whether a person is an immediate family member.

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

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

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

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

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

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

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

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

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

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

(ii) a client may exclude the face value, up to $7,500, plus accrued interest in any combination of irrevocable contract, revocable prepaid account, designated account or cash value in life insurance policies not used to fund the burial policy, regardless of the face value, provided the cash value in policies and designated accounts does not exceed $1500. When the amount exceeds $7,500, the client 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 client.

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

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

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

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

(C) Mortgages (including contracts for deed) and notes which

are income producing are liquid countable resources.

(9) **Trust accounts.** Monies held in trust for an individual applying for or receiving Medicaid 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 Medicaid, copies of the following documents are obtained:

(i) Trust document;

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

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

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

(i) **Support trust.** The purpose of a support trust is the provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (I)-(III) of this unit, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:

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

(II) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and

(III) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available. If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that Medicaid benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

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

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

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

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

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

(iii) **Special needs trusts.** Some trusts may provide that trust benefits are intended only for a beneficiary's "special needs" and require the trustee to take into consideration the availability of public benefits and resources, including Medicaid benefits. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including Medicaid 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 by the individual for purposes of the asset transfer rules and are subject to the 60 months

look back period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(X) An example trust is included on OKDHS form M-11. Social Workers may give this to the client 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 Department of Human Services and may not be amended without the permission of the Department of Human Services;

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

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

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

(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**. An annuity gives the right to receive fixed, periodic payments either for life or a term of years. An annuity also meets the general definition of a trust, because it is a legal entity created by a grantor for the benefit of designated beneficiaries, under the management of some individual or entity with fiduciary responsibility to manage the trust for the benefit of the beneficiaries. Because an annuity meets this definition of a trust, it is treated as a trust. This means 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 client will receive fair market value from the annuity during his/her projected lifetime. Any funds used to purchase the annuity that will not be repaid to the client during his/her projected lifetime, are a transfer of assets and the appropriate penalty period is imposed. ■ 8

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

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

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

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

(11) **Automobiles, pickups, and trucks**. Automobiles, pickups, and trucks are considered in the eligibility determination for Medicaid 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 "av'g. Trade In" value as shown in the current publication of the National Automobile Dealers Association (NADA) on "Cars, Trucks, and Imports" which is provided monthly to each county office by the OKDHS State Office.

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

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

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

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

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

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

(f) **Maximum reserve.** Maximum reserve is a term used to designate the largest amount which a recipient can have in one or more nonexempt resources, and still be considered to be in need. A recipient's reserve may be held in any form or combination of

forms. If the resources of the applicant or recipient 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 legal age of 18 living with parent(s) whose needs are not included in an 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 up to the legal age of 18 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.

(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.