
POLICY TRANSMITTAL NO. 07-68	DATE: DECEMBER 7, 2007
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS AND POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-3-57; 30-5-86.1; 30-5-95; 30-5-95.7; 30-5-95.16 through 30-5-95.17; 30-5-95.19; 30-5-95.22; 30-5-95.24; 30-5-95.31; 30-5-95.33 through 30-5-95.36; 30-5-95.39; 30-5-95.41 through 30-5-95.42; 30-5-96.2; 30-5-210; 30-5-211; 30-5-211.1 through 30-5-211.16; 30-5-212; 30-5-215 through 30-5-218; and 30-5-547.

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

Rules are revised to expand the Disease Management program to include quality measurements, reporting of outcome measurement data, intervention through educational tools for patients and providers, and treatment guidelines for physicians. Rules are needed to comply with Section 6 of the Oklahoma Medicaid Reform Act of 2006.

Inpatient psychiatric hospital rules are revised to establish criteria for newly defined levels of Psychiatric Residential Treatment Facilities (PRTF's). These specialty facilities, which include a higher rate for specialty treatment programs, would allow SoonerCare members to receive treatment in-state as opposed to going out-of-state for these specialty treatments. Revisions are needed to establish staffing ratios, and add definitions and the criteria for use of restraints and seclusion. Inpatient psychiatric hospitals or psychiatric units provide treatment in a hospital setting 24 hours a day and Psychiatric Residential Treatment Facilities provide non-acute inpatient facility care for members who have a behavioral health disorder and need 24-hour supervision and specialized interventions.

Agency Medical Suppliers rules are revised to: (1) include supplier accreditation, medical necessity, prescription, documentation, and prior authorization requirements; (2) address rental, purchase, repairs, maintenance, replacement, and delivery of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); (3) allow SoonerCare members freedom of provider choice; (4) provide guidelines for new billing and reimbursement requirements; and (5)

reorganize rules to be more user friendly by adding definitions and separating services. Additional revisions delete obsolete language and forms and clarify coverage for oxygen, nutritional support, prosthetic devices, and supplies.

Original signed on 11-30-07

Mary Stalnaker, Director
Family Support Services Division

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WF # 07-EE (NAP)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

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

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

REMOVE

317:30-3-57

317:30-5-86.1

317:30-5-95

317:30-5-95.7

317:30-5-95.16

317:30-5-95.17

317:30-5-95.19

317:30-5-95.22

317:30-5-95.24

317:30-5-95.31

317:30-5-95.33

317:30-5-95.34

317:30-5-95.35

317:30-5-95.36

317:30-5-95.39

317:30-5-95.41

INSERT

317:30-3-57, pages 1-5, revised 7-1-07

317:30-5-95, pages 1-3, revised 7-1-07

317:30-5-95.7, 1 page only, revised 7-1-07

317:30-5-95.16, 1 page only, revised 7-1-07

317:30-5-95.17, 1 page only, revised 7-1-07

317:30-5-95.19, 1 page only, revised 7-1-07

317:30-5-95.22, pages 1-2, revised 7-1-07

317:30-5-95.24, pages 1-3, revised 7-1-07

317:30-5-95.31, 1 page only, revised 7-1-07

317:30-5-95.33, pages 1-3, revised 7-1-07

317:30-5-95.34, pages 1-4, revised 7-1-07

317:30-5-95.35, 1 page only, revised 7-1-07

317:30-5-96.36, 1 page only, revised 7-1-07

317:30-5-95.39, pages 1-3, revised 7-1-07

317:30-5-95.41, 1 page only, revised 7-1-07

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317:30-5-95.42

317:30-5-95.42, pages 1-2, revised 7-1-07

317:30-5-96.2

317:30-5-96.2, pages 1-2, revised 7-1-07

317:30-5-210

317:30-5-210, 1 page only, revised 7-1-07

317:30-5-211

317:30-5-211.1, pages 1-2, issued 7-1-07

317:30-5-211.2, 1 page only, issued 7-1-07

317:30-5-211.3, 1 page only, revised 7-1-07

317:30-5-211.4, 1 page only, issued 7-1-07

317:30-5-211.5, 1 page only, issued 7-1-06

317:30-5-211.6, 1 page only, issued 7-1-07

317:30-5-211.7, 1 page only, issued 7-1-07

317:30-5-211.8, 1 page only, issued 7-1-07

317:30-5-211.9, 1 page only, issued 7-1-07

317:30-5-211.10, 1 page only, issued 7-1-07

317:30-5-211.11, pages 1-2, issued 7-1-07

317:30-5-211.12, 1 page only, issued 7-1-07

317:30-5-211.13, pages 1-2, issued 7-1-07

317:30-5-211.14, 1 page only, issued 7-1-07

317:30-5-211.15, 1 page only, issued 7-1-07

317:30-5-211.16, 1 page only, issued 7-1-07

317:30-5-212

317:30-5-212, 1 page only, revised 7-1-07

317:30-5-215

317:30-5-216

317:30-5-216, pages 1-2, reissued 7-1-07

317:30-5-217

317:30-5-217, 1 page only, revised 7-1-07

317:30-5-218

317:30-5-218, 1 page only, revised 7-1-07

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317:30-5-547

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317:30-5-547, 1 page only, revised 7-1-07

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

The following are general SoonerCare coverages for the categorically needy:

- (1) Inpatient hospital services other than those provided in an institution for mental diseases.
 - (A) Adult coverage for inpatient hospital stays as described at OAC 317:30-5-41.
 - (B) Coverage for members under 21 years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.
- (2) Emergency department services.
- (3) Dialysis in an outpatient hospital or free standing dialysis facility.
- (4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.
- (5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with OHCA.
- (6) Outpatient Mental Health Services for medical and remedial care including services provided on an outpatient basis by certified hospital based facilities that are also qualified mental health clinics.
- (7) Rural health clinic services and other ambulatory services furnished by rural health clinic.
- (8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.
- (9) Maternity Clinic Services.
- (10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.
- (11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.
- (12) Nursing facility services (other than services in an institution for tuberculosis or mental diseases).
- (13) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under 21 years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services.

These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA Child Health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.4.

(A) Child health screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.

(C) Immunizations.

(D) Outpatient care.

(E) Dental services as outlined in OAC 317:30-3-65.8.

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one visual screening and glasses each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected.

(G) Hearing services as outlined in OAC 317:30-3-65.9.

(H) Prescribed drugs.

(I) Outpatient Psychological services as outlined in OAC 317:30-5-275 through OAC 317:30-5-278.

(J) Inpatient Psychotherapy services and psychological testing as outlined in OAC 317: 30-5-95 through OAC 317:30-5-97.

(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.

(L) Inpatient hospital services.

(M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of SoonerCare.

(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members 21 years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least 30 days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a nursing facility, ICF/MR, or

elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

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

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

(17) Free-standing ambulatory surgery centers.

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

- (A) unlimited medically necessary monthly prescriptions for:
 - (i) members under the age of 21 years; and
 - (ii) residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded.
- (B) seven medically necessary generic prescriptions per month in addition to the six covered under the State Plan are allowed for adults receiving services under the '1915(c) Home and Community Based Services Waivers. These additional medically necessary prescriptions beyond the three brand name or thirteen total prescriptions are covered with prior authorization.

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

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

(21) Dental services for members residing in private ICF/MR's in accordance with the scope of dental services for members under age 21.

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

(23) Standard medical supplies.

(24) Eyeglasses under EPSDT for members under age 21. Payment

is also made for glasses for children with congenital aphakia or following cataract removal.

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

(26) Inpatient services for members age 65 or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.

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

(28) Inpatient psychiatric facility admissions for members under 21 are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.

(29) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.

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

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

(32) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a R.N.

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

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

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

(36) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security

Act.

(D) Finally, procedures considered experimental or investigational are not covered.

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

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

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

(40) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.

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

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

(43) Birthing center services.

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

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

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

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

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

(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

317:30-5-95. General provisions and eligible providers

(a) Inpatient psychiatric hospitals or psychiatric units provide treatment in a hospital setting 24 hours a day. Psychiatric Residential Treatment Facilities (PRTF) provide non-acute inpatient facility care for members who have a behavioral health disorder and need 24-hour supervision and specialized interventions. Payment for psychiatric and/or chemical dependency/detoxification services for adults between the ages of 21 and 64 are limited to acute inpatient hospital settings.

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

(1) **"AOA"** means American Osteopathic Accreditation.

(2) **"CARF"** means the Commission on Accreditation of Rehabilitation Facilities.

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

(4) **"Licensed independent practitioner (LIP)"** means any individual permitted by law and by the licensed hospital to provide care and services, without supervision, within the scope of the individual's license and consistent with clinical privileges individually granted by the licensed hospital. Licensed independent practitioners may include Advanced Practice Nurses (APN) with prescriptive authority and Physician Assistants.

(5) **"Psychiatric Residential Treatment Facility (PRTF)"** means a facility other than a hospital.

(6) **"Restraint"** means any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely, or drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not the standard treatment or dosage for the patient's condition. Restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include physical escort).

(7) **"Seclusion"** means the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving and may only be used for the management

of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

(c) **Hospitals and freestanding psychiatric facilities.** To be eligible for payment under this Section, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that is:

- (1) appropriately licensed and surveyed by the state survey agency;
- (2) accredited by JCAHO; and
- (3) contracted with the Oklahoma Health Care Authority (OHCA).

(d) **Psychiatric Residential Treatment Facility (PRTF).** A PRTF is any non-hospital facility contracted with the OHCA to provide inpatient services to SoonerCare eligible members under the age of 21. To enroll as a hospital-based or freestanding PRTF, the provider must be appropriately state licensed pursuant to Title 10 O.S. '402 and approved by the OHCA to provide services to individuals under age 21. Out-of-state PRTFs should be appropriately licensed in the state in which they do business. In addition, the following requirements must be met:

(1) **Restraint and seclusion reporting requirements.** In accordance with Federal Regulations at 42 CFR 483.350, the OHCA requires a PRTF that provides SoonerCare inpatient psychiatric services to members under age 21 to attest, in writing, that the facility is in compliance with all of the standards governing the use of restraint and seclusion. The attestation letter must be signed by an individual who has the legal authority to obligate the facility. OAC 317:30-5-95.39 describes the documentation required by the OHCA.

(2) **Attestation letter.** The attestation letter at a minimum must include:

- (A) the name and address, telephone number of the facility, and a provider identification number;
- (B) the signature and title of the individual who has the legal authority to obligate the facility;
- (C) the date the attestation is signed;
- (D) a statement certifying that the facility currently meets all of the requirements governing the use of restraint and seclusion;
- (E) a statement acknowledging the right of the State Survey Agency (or its agents) and, if necessary, Center for Medicare and Medicaid Services (CMS) to conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged

against the facility, or to investigate serious occurrences;
(F) a statement that the facility will notify the OHCA and the State Health Department if it no longer complies with the requirements; and

(G) a statement that the facility will submit a new attestation of compliance in the event the individual who has the legal authority to obligate the facility is no longer in such position.

(3) **Reporting of serious injuries or deaths.** Each PRTF is required to report a resident's death, serious injury, and a resident's suicide attempt to the OHCA, and unless prohibited by state law, to the state-designated Protection and Advocacy System (P and As). In addition to reporting requirements contained in this section, facilities must report the death of any resident to the CMS regional office no later than close of business the next business day after the resident's death. Staff must document in the resident's record that the death was reported to the CMS Regional Office.

(e) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.

**MEDICAL PROVIDERS-FEE FOR SERVICE
INPATIENT PSYCHIATRIC HOSPITALS SPECIFIC**

OAC 317:30-5-95.7

317:30-5-95.7. Active treatment for adults age 21 to 64

Active treatment must be provided to each adult member age 21 to 64. The active treatment program must be appropriate to the needs _____ and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender.

**MEDICAL PROVIDERS-FEE FOR SERVICE
INPATIENT PSYCHIATRIC HOSPITALS SPECIFIC**

OAC 317:30-5-95.16

317:30-5-95.16. Medical psychiatric and social evaluations for persons over 65 years of age receiving inpatient acute psychiatric services

The record of a member over 65 years of age receiving inpatient acute psychiatric services must contain complete medical, psychiatric and social evaluations.

(1) The evaluations must be completed as follows:

(A) History and Physical must be completed within 48 hours of admission by a licensed independent practitioner [M.D., D.O., Advanced Practice Nurse (A.P.N.), or Physician Assistant (P.A.)].

(B) Psychiatric Evaluation must be completed within 48 hours of admission by a M.D. or D.O.

(C) Psychosocial Evaluation must be completed within 72 hours of admission by a licensed independent practitioner or a licensed behavioral health professional (LBHP) as defined in OAC 317:30-5-240(c).

(2) The evaluations must be clearly identified as such and must be signed and dated by the evaluator.

**MEDICAL PROVIDERS-FEE FOR SERVICE
INPATIENT PSYCHIATRIC HOSPITALS SPECIFIC**

OAC 317:30-5-95.17

317:30-5-95.17. Active treatment for persons over 65 years of age receiving inpatient acute psychiatric services

Active treatment must be provided to each member over 65 years of age who is receiving inpatient acute psychiatric services. The active treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender.

317:30-5-95.19. Therapeutic services for persons over 65 years of age receiving inpatient acute psychiatric services

An interdisciplinary team of a physician, LBHPs, registered nurse, and other staff who provide services to members over 65 years of age who are receiving inpatient acute psychiatric services in the facility oversee all components of the active treatment and provide services appropriate to their respective discipline. The team developing the individual plan of care must include, at a minimum, the following:

- (1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and
- (2) a LBHP licensed to practice by one of the following boards:
 - (A) Psychology (health service specialty only);
 - (B) Social Work (clinical specialty only);
 - (C) Licensed Professional Counselor;
 - (D) Licensed Behavioral Practitioner;
 - (E) Licensed Marital and Family Therapist; or
 - (F) Advanced Practice Nurse (certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided); and
- (3) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

**MEDICAL PROVIDERS-FEE FOR SERVICE
INPATIENT PSYCHIATRIC HOSPITALS SPECIFIC OAC 317:30-5-95.22 (p1)**

317:30-5-95.22 Coverage for children

(a) In order for services to be covered, services in acute hospitals, free-standing hospitals, and Psychiatric Residential Treatment Facilities must meet the requirements in OAC 317:30-5-95.25 through 317:30-5-95.30. OHCA rules that apply to inpatient psychiatric coverage for children are found in Sections OAC 317:30-5-95.24 through 317:30-5-95.42.

(b) **Definitions.** The following words and terms, when used in Sections OAC 317:30-5-95.22 through 317:30-5-95.42, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Acute care"** means care delivered in a psychiatric unit of a general hospital or free-standing psychiatric hospital that provides assessment, medical management and monitoring, and short-term intensive treatment and stabilization to individuals experiencing acute episodes of behavioral health disorders.

(2) **"Border Placement"** means a placement in a facility that is in one of the states that borders Oklahoma (Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas). Border "status" may include other states that routinely provide PRTF services. Providers are subject to the same OHCA rules and program requirements as in-state providers, including claims submission procedures and are paid the same daily per diem as Oklahoma providers.

(3) **"Chemical Dependency/Substance Abuse services/Detoxification"** means services offered to individuals with a substance-related disorder whose biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care.

(4) **"Designated Agent"** means the entity contracted with the OHCA to provide certain services to meet federal and state statutory obligations of the OHCA.

(5) **"Enhanced Treatment Unit or Specialized Treatment Unit"** means an intensive residential treatment unit that provides a program of care to a population with a special need or issues requiring increased staffing requirements, co-morbidities and longer lengths of stay.

(6) **"Evidenced Based Practice (EBP)"** according to the Substance Abuse and Mental Health Services Administration (SAMHSA) means programs or practices that are supported by research methodology and have produced consistently positive patterns of results.

(7) **"Out-of-State Placement"** means a placement for intensive or specialized services not available in Oklahoma requiring additional authorization procedures and approval by the OHCA Behavioral Health Unit.

MEDICAL PROVIDERS-FEE FOR SERVICE

INPATIENT PSYCHIATRIC HOSPITALS SPECIFIC OAC 317:30-5-95.22 (p2)

(8) **"Residential Treatment services"** means psychiatric services that are designed to serve children who need longer term, more intensive treatment, and a more highly structured environment than they can receive in family and other community based alternatives to hospitalization.

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

MEDICAL PROVIDERS-FEE FOR SERVICE
INPATIENT PSYCHIATRIC HOSPITALS SPECIFIC OAC 317:30-5-95.24(p1)

317:30-5-95.24. Pre-authorization of inpatient psychiatric services for children

(a) All inpatient psychiatric services for members under 21 years of age must be prior authorized by the OHCA or its designated agent. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Additional information will be required for a SoonerCare compensable approval on enhanced treatment units or in special population programs. Residential treatment at this level is a longer term treatment that requires a higher staff to patient ratio because it is constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic patients) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one time a week. A PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit and will require a contract addendum. A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the children.

(b) Criteria for classification as a specialized PRTF will require a staffing ratio of 1:3 at a minimum during awake hours and 1:6 during time residents are asleep with 24 hour nursing care supervised by a RN for management of behaviors and medical complications. The PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions will be restricted to children that meet the medical necessity criteria for RTC and also meet at least two or more of the following:

(1) Have failed at other levels of care or have not been accepted at other levels of care;

(2) Behavioral, emotional, and cognitive problems requiring secure residential treatment that includes 1:1, 1:2, or 1:3 staffing due to the patient being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive and stereotyped behaviors.

These symptoms are severe and intrusive enough that management and treatment in a less restrictive environment places the child and others in danger but, do not meet acute medical necessity criteria. These symptoms which are exhibited across multiple environments must include at least two or more of the following:

(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body

MEDICAL PROVIDERS-FEE FOR SERVICE
INPATIENT PSYCHIATRIC HOSPITALS SPECIFIC OAC 317:30-5-95.24(p2)

- postures, and gestures to regulate social interaction;
- (B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;
- (C) Failure to develop peer relationships appropriate to developmental level;
- (D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;
- (E) Lack of social or emotional reciprocity;
- (F) Lack of attachment to caretakers;
- (G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues 50 percent of the time to complete tasks;
- (H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;
- (I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;
- (J) Stereotyped and repetitive use of language or idiosyncratic language;
- (K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;
- (L) Encompassing preoccupation with one or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;
- (M) Inflexible adherence to specific, nonfunctional routines or rituals;
- (N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements);
- (O) Persistent occupation with parts of objects;

(3) Patient is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment;

(4) Full scale IQ below 40 (profound mental retardation).

(c) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

(d) The designated agent will prior authorize all services for an approved length of stay based on the medical necessity criteria described in OAC 317:30-5-95.25 through 317:30-5-95.31.

(e) Out of state placements must be approved by the agent designated by the OHCA and subsequently approved by the OHCA, Medical Services Behavioral Health Division. Requests for

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admission to Psychiatric Residential Treatment Facilities or acute care units will be reviewed for consideration of level of care, availability, suitability, and proximity of suitable services. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate.

(f) Inpatient psychiatric services in all acute hospitals and psychiatric residential treatment facilities are limited to the approved length of stay. The Agent designated by the OHCA will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria and following the current inpatient provider manual approved by the OHCA. The approved length of stay applies to both hospital and physician services.

317:30-5-95.31. Pre-authorization and extension procedures for children

(a) Pre-admission authorization for inpatient psychiatric services for children must be requested from the OHCA designated agent. The OHCA or designated agent will evaluate and render a decision within 24 hours of receiving the request. A prior authorization will be issued by the OHCA or its designated agent, if the member meets medical necessity criteria. For the safety of SoonerCare members, additional approval from the OHCA designated agent is required for placement on specialty units or in special population programs or for members with special needs such as very low intellectual functioning.

(b) Extension requests (psychiatric) must be made through the OHCA designated agent. All requests are made prior to the expiration of the approved extension following the guidelines in the Inpatient Provider Manual published by the OHCA designated agent. Requests for the continued stay of a child who has been in an acute psychiatric program for a period of 15 days and in a psychiatric residential treatment facility for 3 months will require a review of all treatment documentation completed by the OHCA designated agent to determine the efficiency of treatment.

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

(d) In the event a member disagrees with the decision by the OHCA's designated agent, the member receives an evidentiary hearing under OAC 317:2-1-2(a). The member's request for such an appeal must commence within 20 calendar days of the initial decision.

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317:30-5-95.33. Individual plan of care for children

(a) The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) "**Licensed Behavioral Health Professional (LBPH)**" means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), and advanced practice nurses (APN).

(2) "**Individual plan of Care (IPC)**" means a written plan developed for each member within four calendar days of any admission to a PRTF and is the document that directs the care and treatment of that member. The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:

(A) the complete record of the DSM-IV-TR five-axis diagnosis, including the corresponding symptoms, complaints, and complications indicating the need for admission;

(B) the current functional level of the individual;

(C) treatment goals and measurable time limited objectives;

(D) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient;

(E) plans for continuing care, including review and modification to the plan of care; and

(F) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.

(b) The individual plan of care:

(1) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;

(2) must be developed by a team of professionals as specified in OAC 317:30-5-95.35 in collaboration with the member, and his/her parents for members under the age of 18, legal guardians, or others in whose care he/she will be released after discharge;

(3) must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goal must be appropriate to the patient's age, culture, strengths, needs, abilities, preferences and limitations;

(4) must establish measurable and time limited treatment

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objectives that reflect the expectations of the member served and parent/legal guardian (when applicable) as well as being age, developmentally and culturally appropriate. When modifications are being made to accommodate age, developmental level or a cultural issue, the documentation must be reflected on the individual plan of care. The treatment objectives must be achievable and understandable to the member and the parent/guardian (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

(5) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;

(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into their family school, and community;

(7) must be reviewed at least every seven calendar days when in acute care and a regular PRTF and every 14 calendar days in the OHCA approved longer term treatment programs or specialty PRTF treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,

(9) each individual plan of care review must be clearly identified as such and be signed and dated individually by the physician, LBHP, member, parent/guardian (for patients under the age of 18), registered nurse, and other required team members. Individual plans of care and individual plan of care reviews are not valid until completed and appropriately signed and dated. All requirements for the individual plan of care or individual plan of care reviews must be met or a partial per diem recoupment will be merited. In those instances where it is necessary to fax an Individual Plan of Care or Individual Plan of Care review to a parent or OKDHS/OJA worker for review, the parent and/or OKDHS/OJA worker may fax back their signature. The Provider must obtain the original signature for the clinical

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file within 30 days. Stamped or Xeroxed signatures are not allowed for any parent or member of the treatment team.

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317:30-5-95.34. Active treatment for children

(a) The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (ROPES), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(2) **"Family therapy"** means interaction between a LBHP, member and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.

(3) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living.

(4) **"Individual rehabilitative treatment"** means a face to face, one on one interaction which is performed to assist members who are experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform activities of daily living.

(5) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face to face, one on one interaction between a LBPH and a member to promote emotional or psychological change to alleviate disorders.

(6) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between a LBHP as defined in OAC 317:30-5-240(c), and two or more patients to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "Active Treatment".

Active Treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. For individuals in the age range of 18 up to 21, it is understood that family members and guardians will not always be involved in the member's treatment. Active Treatment also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician.

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Evidence based practices such as trauma informed methodology should be utilized to minimize the use of seclusion and restraint.

(c) The components of Active Treatment consist of integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age, and gender. Sixty minutes is the expectation to equal one hour of treatment. The following components meet the minimum standards required for Active Treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) Individual treatment provided by the physician. Individual treatment provided by the physician is required three times per week for acute care and one time a week in Residential Treatment Facilities. Individual treatment provided by the physician will never exceed ten days between sessions in PRTFs and never exceed seven days in a specialty PRTF. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.

(2) Individual therapy. LBHPs performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal directed utilizing techniques appropriate to the individual patient's plan of care and the patient's developmental and cognitive abilities. Individual therapy must be provided two hours per week in acute care and one hour per week in residential treatment by a LBHP as described in OAC 317:30-5-240(c). One hour of family therapy may be substituted for one hour of individual therapy at the treatment team's discretion.

(3) Family therapy. The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one hour per week for acute care and residential treatment for members under the age of 18. One hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by a LBHP as described in OAC 317:30-5-240(c).

(4) Process group therapy. The focus of process group therapy must be directly related to goals and objectives on the individual

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member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three hours per week in acute care and two hours per week in residential treatment by a LBHP as defined in OAC 317:30-5-240(c). In lieu of one hour of process group therapy, one hour of expressive group therapy may be substituted.

(5) Expressive group therapy. Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant Bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy. Expressive group therapy must be provided four hours per week in acute care and three hours per week in residential treatment. In lieu of one hour of expressive group therapy, one hour of process group therapy may be substituted.

(6) Group Rehabilitative treatment. Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives, directly related to the individual plan of care. Group rehabilitative treatment services will be provided two hours each day for all inpatient psychiatric care. In lieu of two hours of group rehabilitative services per day, one hour of individual rehabilitative services per day may be substituted.

(7) Individual rehabilitative treatment. Services will be for the reduction of psychiatric and behavioral impairment and the restoration of functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the individualized plan of care and the patient's diagnosis. One hour of individual rehabilitative

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treatment service may be substituted daily for the two hour daily group rehabilitative services requirement.

(8) Modifications to active treatment. When a member is too physically ill or their acuity level precludes them from active behavioral health treatment, documentation must demonstrate that alternative clinically appropriate services were provided.

317:30-5-95.35. Credentialing requirements for treatment team members for children

(a) The team developing the individual plan of care for the child must include, at a minimum, the following:

(1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U), and

(2) a mental health professional licensed to practice by one of the following boards: Psychology (health service specialty only); Social Work (clinical specialty only); Licensed Professional Counselor, Licensed Behavioral Practitioner, (or) Licensed Marital and Family Therapist or Advanced Practice Nurse (certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided), and

(3) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

(b) Candidates for licensure for Licensed Professional Counselor, Social Work (clinical specialty only), Licensed Marital and Family Therapist, Licensed Behavioral Practitioner and Psychology (health services specialty only) can provide individual therapy, family therapy and process group therapy as long as they are involved in the supervision that complies with their respective approved licensing regulations and the Department of Health and their work must be co-signed by a licensed LBHP who is additionally a member on the treatment team. Individuals who have met their supervision requirements and are waiting to be licensed by one of the licensing boards in OAC 317:30-5-95.35(a)(1) must have their work co-signed by a licensed MHP who is additionally a member on the treatment team.

(c) Services provided by treatment team members not meeting the above credentialing requirements are not Medicaid compensable and can not be billed to the Medicaid recipient.

317:30-5-95.36. Treatment team for inpatient children's services

An interdisciplinary team of a physician, mental health professionals, registered nurse, patient, parent/legal guardian for members under the age of 18, and other personnel who provide services to members in the facility must develop the individual plan of care, oversee all components of the active treatment and provide the services appropriate to their respective discipline. Based on education and experience, preferably including competence in child psychiatry, the teams must be:

- (1) capable of assessing the member's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities;
- (2) capable of assessing the potential resources of the member's family, and actively involving the family of members under the age of 18 in the ongoing plan of care;
- (3) capable of setting treatment objectives;
- (4) capable of prescribing therapeutic modalities to achieve the plan objectives;
- (5) capable of developing appropriate discharge criteria and plans; and
- (6) trained in a recognized behavioral/management intervention program such as MANDT System, Controlling Aggressive Patient Environment (CAPE), SATORI, Professional Assault Crisis Training (PRO-ACT), or a trauma informed methodology with the utmost focus on the minimization of seclusion and restraints.

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317:30-5-95.39. Seclusion, restraint, and serious incident reporting requirements for children

(a) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the member, a staff member or others from harm and may only be imposed to ensure the immediate physical safety of the member, a staff member or others. The use of restraint or seclusion must be in accordance with a written modification to the member's individual plan of care. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the member or others from harm. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

(1) Each facility must have policies and procedure to describe the conditions in which seclusion and restraint would be utilized, the behavioral/management intervention program followed by the facility and the documentation required. Each order by a physician or Licensed Independent Practitioner (LIP) may authorize the RN to continue or terminate the restraint or seclusion based on the member's face to face evaluation. Each order for restraint or seclusion may only be renewed in accordance with the following limits for up to a total of 24 hours:

(A) four hours for children 18 to 20 years of age;

(B) two hours for children and adolescents nine to 17 years of age; or

(C) one hour for children under nine years of age.

(2) The documentation required to insure that seclusion and restraint was appropriately implemented and monitored will include at a minimum:

(A) documentation of events leading to intervention used to manage the violent or self-destructive behaviors that jeopardize the immediate physical safety of the member or others;

(B) documentation of alternatives or less restrictive interventions attempted;

(C) an order for seclusion/restraint including the name of the LIP, date and time of order;

(D) orders for the use of seclusion/restraint must never be written as a standing order or on an as needed basis;

(E) documentation that the member continually was monitored face to face by an assigned, trained staff member, or continually monitored by trained staff using both video and audio equipment during the seclusion/restraint;

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(F) the results of a face to face assessment completed within one hour by a LIP or RN who has been trained in accordance with the requirements specified at OAC 317:30-5-95.35 to include the:

- (i) member's immediate situation;
- (ii) member's reaction to intervention;
- (iii) member's medical and behavioral conditions; and
- (iv) need to continue or terminate the restraint or seclusion.

(G) in events the face to face was completed by a trained RN, documentation that the trained RN consulted the attending physician or other LIP responsible for the care of the member as soon as possible after the completion of the one-hour face to face evaluation;

(H) debriefing of the child within 24 hours by a LBHP;

(I) debriefing of staff within 48 hours; and

(J) notification of the parent/guardian.

(b) Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a member in restraint or seclusion before performing any of these actions and subsequently on an annual basis. The PRTF must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

(1) techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion;

(2) the use of nonphysical intervention skills;

(3) choosing the least restrictive intervention based on an individualized assessment of the member's medical behavior status or condition;

(4) the safe application and use of all types of restraint or seclusion used in the PRTF, including training in how to recognize and respond to signs of physical and psychological distress;

(5) clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary;

(6) monitoring the physical and psychological well being of the member who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by the policy of the PRTF associated with the one hour face to face evaluation; and

(7) the use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including annual re-

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certification.

(c) Individuals providing staff training must be qualified as evidence by education, training and experience in techniques used to address members' behaviors. The PRTF must document in staff personnel records that the training and demonstration of competency were successfully completed.

(d) The process by which a facility is required to inform the OHCA of a death, serious injury, or suicide attempt is as follows:

(1) The hospital administrator, executive director, or designee is required to contact the OHCA Behavioral Health Unit by phone no later than 5:00 p.m. on the business day following the incident.

(2) Information regarding the SoonerCare member involved, the basic facts of the incident, and follow-up to date must be reported. The agency will be asked to supply, at a minimum, follow-up information with regard to patient outcome, staff debriefing and programmatic changes implemented (if applicable).

(3) Within three days, the OHCA Behavioral Health Unit must receive the above information in writing (example: Facility Critical Incident Report).

(4) Patient death must be reported to the OHCA Behavioral Health Services Unit as well as to the Centers for Medicare and Medicaid Regional office in Dallas, Texas.

(5) Compliance with seclusion and restraint reporting requirements will be verified during the onsite inspection of care see OAC 317:30-5-95.42, or using other methodologies.

317:30-5-95.41. Documentation of records for children's inpatient services

(a) All documentation for services provided under active treatment must be documented in an individual note and reflect the content of each session provided. Individual, Family, Process Group, Expressive Group, Individual Rehabilitative and Group Rehabilitative Services documentation must include, at a minimum, the following:

- (1) date;
- (2) start and stop time for each session;
- (3) signature of the therapist and/or staff that provided the service;
- (4) credentials of the therapist;
- (5) specific problem(s) addressed (problems must be identified on the plan of care);
- (6) method(s) used to address problems;
- (7) progress made towards goals;
- (8) member's response to the session or intervention; and
- (9) any new problem(s) identified during the session.

(b) Signatures of the member, parent/guardian for members under the age of 18, doctor, Licensed Behavioral Health Professional (LBHP), and RN are required on the individual plan of care and all plan of care reviews. The individual plan of care and plan of care review are not valid until signed and separately dated by the member, parent/legal guardian for members under the age of 18, doctor, RN, LBHP, and all other requirements are met. All treatment team staff providing individual therapy, family therapy and process group therapy must sign the individual plan of care and all plan of care reviews.

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317:30-5-95.42. Inspection of care of psychiatric facilities providing services to children

(a) There will be an on site Inspection of Care (IOC) of each psychiatric facility that provides care to SoonerCare eligible children which will be performed by the OHCA or its designated agent. The Oklahoma Health Care Authority will designate the members of the Inspection of Care team.

(b) The IOC team will consist of one to three team members and will be comprised of Licensed Behavioral Health Professionals (LBHP) or Registered Nurses.

(c) The inspection will include observation and contact with members. The Inspection of Care Review will consist of members present or listed as facility residents at the beginning of the Inspection of Care visit as well as members on which claims have been filed with OHCA for acute or PRTF levels of care. The review includes validation of certain factors, all of which must be met for the services to be compensable.

(d) Following the on-site inspection, the Inspection of Care Team will report its findings to the facility. The facility will be provided with written notification if the findings of the inspection of care have resulted in any deficiencies. A copy of the final report will be sent to the facility's accrediting agency.

(e) Deficiencies found during the IOC may result in a partial per-diem recoupment or a full per-diem recoupment of the compensation received. The following documents are considered to be critical to the integrity of care and treatment and must be completed within the time lines designated in OAC 317:30-5-95.37(a)(1) and 317:30-5-95.35(a)(2):

- (1) History and physical evaluation;
- (2) Psychiatric evaluation;
- (3) Psychosocial evaluation; and
- (4) Individual Plan of Care.

(f) For each day that the History and Physical evaluation, Psychiatric evaluation, Psychosocial evaluation and Individual Plan of Care are not contained within the member's records, those days will warrant a full per-diem recoupment of the compensation received. Full per-diem recoupment will only occur for those documents.

(g) If the review findings have resulted in a partial per-diem recoupment of \$50.00 per event, the days of service involved will be reported in the notification. If the review findings have resulted in full per diem recoupment status, the non-compensable days of service will be reported in the notification. In the case of non-compensable days full per diem or partial per diem, the facility will be required to refund the amount.

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(h) Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.

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317:30-5-96.2. Payments definitions

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

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

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

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

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

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

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

"Free-standing, Small" means generally a small, non-secure PRTF with 16 beds or more but less than 32 beds. These facilities may or may not have lock-down.

"Free-standing, Medium" means generally a secure PRTF with bed size ranging from 32 to 49 beds. Some may be non-secure.

"Free-standing, Large" means generally a for-profit, secure PRTF with bed size ranging for 50 to over 100 beds. Some may be non-secure.

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

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

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

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

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

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

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

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

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

317:30-5-210. Eligible providers

All eligible medical suppliers must have a current contract with the Oklahoma Health Care Authority. The supplier must comply with all applicable State and Federal laws. Effective January 1, 2008, all suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) must be accredited by a Medicare deemed accreditation organization for quality standards for DMEPOS suppliers in order to bill the SoonerCare program. OHCA may make exceptions to this standard if it is determined that a supplier may provide acceptable service to an under served location.

317:30-5-211.1. Definitions

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

"Adaptive equipment" means devices, aids, controls, appliances or supplies of either a communication or adaptive type, determined necessary to enable the person to increase his or her ability to function in a home and community based setting or private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) with independence and safety.

"Capped rental" means monthly payments for the use of the Durable Medical Equipment (DME) for a limited period of time not to exceed 13 months. Items are considered purchased after 13 months of continuous rental.

"Certificate of medical necessity (CMN)" means a certificate required to help document the medical necessity and other coverage criteria for selected items, those items are defined in this Chapter. The physician's certification must include the member's diagnosis, the reason the equipment is required, and the physician's estimate, in months, of the duration of its need.

"Customized DME" means items of DME which have been uniquely constructed or substantially modified for a specific member according to the description and orders of the member's treating physician. For instance, a wheelchair would be considered "customized" if it has been:

(A) measured, fitted or adapted in consideration of the member's body size, disability, period of need, or intended use;

(B) assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs; and

(C) intended for an individual member's use in accordance with instructions from the member's physician.

"DME information form (DIF)" means a document used to provide additional information needed to process a claim. The DIF is completed by the supplier and is not reviewed and signed by the physician. In the event of a post payment audit, the supplier must be able to produce the DIF and, if requested, produce information to substantiate the information on the DIF.

"Durable medical equipment (DME)" means equipment that can withstand repeated use, i.e.; the type of item that could normally be rented is used to serve a medical purpose, is not useful to a person in the absence of an illness or injury, and is used in the most appropriate setting including the home or workplace.

"Invoice" means a document that provides the following

information when applicable; description of product, quantity, quantity in box, purchase price (less any discounts, rebates or commissions received), NDC, strength, dosage, provider, seller's name and address, purchaser's name and address and date of purchase. At times, visit notes will be required to determine how much of the supply was expended. When possible, the provider should identify the SoonerCare member receiving the equipment or supply on the invoice.

"**Medical supplies**" means an article used in the cure, mitigation, treatment, prevention, or diagnosis of illnesses. Disposable medical supplies are medical supplies consumed in a single usage and do not include skin care creams or cleansers. Medical supplies do not include surgical supplies or medical or surgical equipment.

"**OHCA CMN**" means a certificate required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this chapter. The physician's certification must include the member's diagnosis, the reason equipment is required, and the physician's estimate, in months, of the duration of its need. This certificate is used when the OHCA requires a CMN and one has not been established by CMS.

"**Orthotics**" means an item used for the correction or prevention of skeletal deformities.

"**Prosthetic devices**" means a replacement, corrective, or supportive device (including repair and replacement parts for same) worn on or in the body, to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.

317:30-5-211.2. Medical necessity

(a) Coverage. Coverage is subject to the requirement that the equipment be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning or malformed body member. The member's diagnosis must warrant the type of equipment or supply being purchased or rented.

(b) Prescription requirements. All DME, except for hearing aid batteries, require a prescription signed by a physician, a physician assistant, or an advanced practice nurse. Except as otherwise stated in state or federal law, the prescription must be in writing, or given orally and later reduced to writing by the provider filling the order. Prescriptions are valid for no more than one year from the date written. The prescription must include the following information:

- (1) date of the order;
- (2) name and address of the prescriber;
- (3) name and address of the member;
- (4) name or description and quantity of the prescribed item;
- (5) diagnosis for the item requested;
- (6) directions for use of the prescribed item; and
- (7) prescriber's signature.

(c) Certificate of medical necessity. For certain items or services, the supplier must receive a signed CMN/OHCA CMN from the treating physician. The supplier must have a signed CMN/OHCA CMN in their records before they submit a claim for payment. The CMN/OHCA CMN may be faxed, copied or the original hardcopy.

(d) Place of service.

(1) OHCA covers DMEPOS for use in the member's place of residence except if the member's place of residence is a nursing facility.

(2) For members residing in a nursing facility, most medical supplies and/or DME are considered part of the facility's per diem rate. Refer to coverage for nursing facility residents at OAC 317:30-5-211.16.

317:30-5-211.3. Prior authorization (PA)

(a) General. Prior authorization is the electronic or written authorization issued by OHCA to a provider prior to the provision of a service. Providers should obtain a PA before providing services. Prior Authorization is designed to:

- (1) safeguard against unnecessary or inappropriate care and services;
- (2) safeguard against excessive payments;
- (3) assess the quality and timeliness of services;
- (4) promote the most effective and appropriate use of available services and facilities;
- (5) determine if less expensive alternative care, services, or supplies are permissible; and
- (6) curtail inaccurate utilization practices of providers and members.

(b) Requirements. The following services require prior authorization:

- (1) services that exceed quantity/frequency limits or established fees;
- (2) medical need for an item is beyond OHCA's standards of coverage;
- (3) use of a Not Otherwise Classified (NOC) code or miscellaneous codes;
- (4) services for which a less costly alternative may exist; and
- (5) procedures indicating PA is required on the OHCA fee schedule.

(c) Prior authorization requests. Refer to OAC 317:30-5-216.

317:30-5-211.4. Rental and/or purchase

(a) **Purchase (New or Used)**. Items may be purchased if they are inexpensive accessories for other DME or the equipment itself will be used for an extended period of time. The OHCA reserves the right to determine whether items of DMEPOS will be rented or purchased.

(b) **Rental**.

(1) Continuous rental. Items that require regular and ongoing servicing/maintenance are rented for the duration indicated by the physician's order and medical necessity. Examples include but are not limited to oxygen and volume ventilators. The rental payment includes routine servicing and all necessary repairs or replacements to make the rented item functional.

(2) Capped rental. Items are rented until purchase price is reached. Capped rental items may be rented for a maximum of 13 months. If the member changes suppliers during or after the 13th continuous month rental period, this does not result in a new rental period. The supplier that provides the item to the member the 13th month of rental is responsible for supplying the equipment, as well as routine maintenance and servicing after the 13th month. If used equipment is issued to the member, the usual and customary charge reported to the OHCA, must accurately reflect that the item is used.

(c) **Converting rental to purchase**. The majority of DME can be rented as a capped rental for up to a maximum of 13 continuous months. When an item is converted to a purchase during the rental period, the provider must subtract the amount already paid for the rental item from the total purchase price.

317:30-5-211.5. Repairs, maintenance, replacement and delivery

(a) Repairs. Repairs to equipment that a member owns are covered when they are necessary to make the equipment usable. The repair charge includes the use of "loaner" equipment as required. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, payment can not be made for the amount in excess.

(b) Maintenance. Routine periodic servicing, such as testing, cleaning, regulating, and checking the member's equipment is considered maintenance and not a separate covered service. However, more extensive maintenance as recommended by the manufacturer and performed by authorized technicians are considered repairs. This may include breaking down sealed components and performing tests that require specialized testing equipment not available to the member. The supplier of a capped rental item that supplied the item the 13th month must provide maintenance and service for the item. In very rare circumstances of malicious damage, culpable neglect, or wrongful disposition, the supplier may document the circumstances and be relieved of the obligation to provide maintenance and service.

(c) Replacement.

(1) If a capped rental item of equipment has been in continuous use by the member for the equipment's useful life or if the item is irreparably damaged, lost, or stolen, a prior authorization must be submitted to obtain new equipment. The reasonable useful life for capped rental equipment cannot be less than five years. Useful life is determined by the delivery of the equipment to the member, not the age of the equipment.

(2) Replacement parts must be billed with the appropriate HCPCS code that represents the item or part being replaced, along with a pricing modifier and replacement modifier. If a part that has not been assigned a HCPCS code is being replaced, the provider should use a miscellaneous HCPCS code to bill each part. Each claim that contains miscellaneous codes for replacement parts must include a narrative description of the item, the brand name, model name/number of the item and an invoice.

(d) Delivery. Delivery costs are included in setting the price for covered items. Delivery costs are not allowed except in rare and unusual circumstances when the delivery is outside the supplier's normal range of operation and cannot be provided by a more local supplier.

317:30-5-211.6. General documentation requirements

Section 1833(e) of the Social Security Act precludes payment to any provider of service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" [42 U.S.S. Section 13951(e)]. The member's medical records will reflect the need for the care provided. The member's medical records should include the physician's office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports. This documentation must be provided for prior authorization requests and available to the OHCA or its designated agent upon request.

**MEDICAL PROVIDERS-FEE FOR SERVICE
MEDICAL SUPPLIERS SPECIFIC**

OAC 317:30-5-211.7

317:30-5-211.7. Free choice

A member has the choice of which provider will fill the prescription or order for a DMEPOS. The prescribing physician should give the written prescription or order to the member in order to allow the member freedom of choice.

317:30-5-211.8. Coverage

Durable medical equipment, adaptive equipment, medical supplies and prosthetic devices prescribed by the appropriate medical provider and medically necessary are covered for adults and children as set forth in this section.

317:30-5-211.9. Adaptive equipment

(a) Residents of ICF/MR facilities. Payment is made for customized adaptive equipment for persons residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR). This includes customized equipment or devices to assist in ambulation. Standard wheelchairs, walkers, eyeglasses, etc. would not be considered customized adaptive equipment. All customized adaptive equipment must be prescribed by a physician and requires prior authorization.

(b) Members in home and community-based waivers. Refer to OAC 317:40-5-100.

317:30-5-211.10. Durable medical equipment (DME)

(a) **DME.** DME includes, but is not limited to; medical supplies, orthotics and prosthetics, custom braces, therapeutic lenses, respiratory equipment and other qualifying items when acquired from a contracted DME provider.

(b) **Certificate of medical necessity.** Certain items of DME require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items include but are not limited to:

- (1) hospital beds;
- (2) support surfaces;
- (3) wheelchairs;
- (4) continuous positive airway pressure devices (BIPAP and CPAP);
- (5) patient lift devices;
- (6) external infusions pumps;
- (7) enteral and parenteral nutrition;
- (8) osteogenesis stimulators; and
- (9) pneumatic compression devices.

(c) **Prior authorization.**

(1) **Rental.** Rental of hospital beds, support surfaces, wheelchairs, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts require prior authorization and a completed CMN/OHCA CMN; medical necessity must be documented in the member's medical record and be signed by the physician.

(2) **Purchase.** Equipment will be purchased when a member requires the equipment for an extended period of time. During the prior authorization review the PA consultant may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted. The provider must indicate whether the DME item provided is new or used.

(d) **Backup equipment.** Backup equipment is considered part of the rental cost and not a covered service without prior authorization.

(e) **Home modification.** Equipment used for home modification is not a covered service.

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

(a) Medical necessity. Oxygen and oxygen supplies are covered when medically necessary. Medical necessity is determined from results of arterial blood gas analysis (ABG) or pulse oximetry tests (pO_2). The test results to document medical necessity must be within 30 days of the date of the physician's prescription. A copy of a report from an inpatient or outpatient hospital or emergency room setting will meet the requirement.

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

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

(A) **Adults.** Initial requests for oxygen must include ABG results, unless the condition of the member is such that they cannot tolerate the invasive test or it is not possible to obtain the test. The prescribing physician must document why oximetry reading is necessary instead of ABG. The arterial blood saturation can not exceed 89% at rest on room air; the pO_2 level can not exceed 59mm Hg.

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

- (i) birth through three years, SaO_2 level equal to or less than 94%; and
- (ii) ages four and above, SaO_2 level equal to or less than 90%.

(b) Certificate of medical necessity.

(1) The medical supplier must have a fully completed current CMN on file to support the claims for oxygen or oxygen supplies, to establish whether coverage criteria are met and to ensure that the oxygen services provided are consistent with the physician's prescription (refer to instructions from Palmetto Government

Benefits Administration, the Oklahoma Medicare Carrier, for further requirements for completion of the CMN).

(2) The CMN must be signed by the physician prior to submitting the initial claim. When a physician prescription for oxygen is renewed, a CMN, including the required retesting, must be completed by the physician prior to the submission of claims. The medical and prescription information on the CMN may be completed by a non physician clinician, or an employee of the physician for the physician's review and signature. In situations where the physician has prescribed oxygen over the phone, it is acceptable to have a cover letter containing the same information as the CMN, stating the physician's orders, as long as the CMN has been signed by the physician or as set out above.

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

317:30-5-211.12. Oxygen rental

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

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

(2) Portable oxygen and portable oxygen content for limited uses such as physician's visits or trips to the hospital are covered items. The reason for use of portable oxygen must be stated on the CMN. A portable system that is used as a standby only is not a covered item.

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

317:30-5-211.13. Prosthetic devices

Prosthetic devices prescribed by an appropriate medical provider as conditioned in this section are covered items.

(1) **Certificate of medical necessity.** The medical supplier must have a fully completed CMN on file for prosthetic items including Transcutaneous Electric Nerve Stimulators (TENS).

(2) **Prior authorization.** Prosthetic devices, except for cataract lenses, require prior authorization.

(3) **Home dialysis.** Equipment and supplies are covered items for members receiving home dialysis treatments only.

(4) **Nerve stimulators.** Payment is made for rental equipment which must not exceed the purchase price, for transcutaneous nerve stimulators, implanted peripheral nerve stimulators, and neuromuscular stimulators. After continuous rental for 13 months, the equipment becomes the property of the OHCA to be used by the member until no longer medically necessary.

(5) **Breast prosthesis, bras, and prosthetic garments.**

(A) Payment is limited to:

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

(ii) two mastectomy bras per year; and

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

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

(B) Payment will not be made for both a silicone and a foam prosthetic in the same 12 month period.

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

(D) A breast prosthesis can be replaced if:

(i) lost;

(ii) irreparably damaged (other than ordinary wear and tear); or

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

(E) External breast prostheses are not covered after breast reconstruction is performed.

(6) **Prosthetic devices inserted during surgery.** Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for

the procedure itself.

317:30-5-211.14. Nutritional support

(a) Parenteral nutrition. The member must require intravenous feedings to maintain weight and strength commensurate with the member's overall health status. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements.

(1) The member must have a permanent impairment. Permanence does not require a determination that there is no possibility that the member's condition may improve sometime in the future.

If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least three months), the test of permanence is met. Parenteral nutrition will be denied as a non-covered service in situations involving temporary impairments.

(2) The member must have a condition involving the small intestine, exocrine glands, or other conditions that significantly impair the absorption of nutrients. Coverage is also provided for a disease of the stomach and/or intestine that is a motility disorder and impairs the ability of nutrients to be transported through the GI system, and other conditions as deemed medically necessary. There must be objective medical evidence supporting the clinical diagnosis.

(3) Re-certification of parenteral nutrition will be required as medically necessary and determined by the OHCA medical staff.

(b) Prior authorization. A written signed and dated order must be received by the supplier before a claim is submitted to the OHCA. If the supplier bills an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary.

(1) The ordering physician is expected to see the member within 30 days prior to the initial certification or required re-certification. If the physician does not see the member within this time frame, the physician must document the reason why and describe what other monitoring methods were used to evaluate the member's parenteral nutrition needs.

(2) A completed DIF must be kept on file by the supplier and made available to the OHCA on request. The initial request for prior authorization must include a copy of the DIF.

(c) Enteral formulas. Enteral formulas are covered for children only. See OAC 317:30-5-212.

317:30-5-211.15. Supplies

(a) The OHCA provides coverage for supplies that are prescribed by the appropriate medical provider, medically necessary and meet the special requirements below.

(b) Special requirements:

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

(2) **Diabetic supplies.** The purchase of one glucometer, one spring loaded lancet device, and replacement batteries as defined by the life of the battery are covered items. In addition, a maximum of 200 glucose test strips and 200 lancets per month when medically necessary and prescribed by a physician are covered items. Diabetic supplies in excess of these parameters must be prior authorized.

(3) **Catheters.** Permanent indwelling catheters, male external catheters, drain bags and irrigation trays are covered items. Single use self catheters when the member has a history of urinary tract infections is a covered item. The prescription from the attending physician must indicate such documentation is available in the member's medical record.

(4) **Colostomy and urostomy supplies.** Colostomy and urostomy bags and accessories are covered items.

317:30-5-211.16. Coverage for nursing facility residents

(a) For residents in a nursing facility, most DMEPOS are considered part of the facility's per diem rate. The following are not included in the per diem rate and may be billed by the appropriate medical supplier:

(1) Services requiring prior authorization:

- (A) ventilators and supplies;
- (B) total parenteral nutrition (TPN), and supplies;
- (C) custom seating for wheelchairs; and
- (D) external breast prosthesis and support accessories.

(2) Services not requiring prior authorization:

- (A) permanent indwelling or male external catheters and catheter accessories;
- (B) colostomy and urostomy supplies;
- (C) tracheostomy supplies;
- (D) catheters and catheter accessories;
- (E) oxygen and oxygen concentrators.

(i) **PRN oxygen.** Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.

(ii) **Billing for Medicare eligible nursing home members.** Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim with OHCA.

(b) Items not covered include but are not limited to:

- (1) diapers;
- (2) underpads;
- (3) medicine cups;
- (4) eating utensils; and
- (5) personal comfort items.

317:30-5-212. Coverage for children

(a) **Coverage.** Coverage of Durable Medical Equipment, Adaptive Equipment, Medical Supplies and Prosthetic Devices for children is the same as for adults. In addition the following are covered items:

(1) All orthotic equipment (procedures) listed by Health Care Finance Administration Common Procedural Code System (HCPCS).

(2) Durable medical equipment, adaptive equipment, medical supplies and prosthetic devices determined to be medically necessary..

(3) Enteral nutrition is considered medically necessary for certain conditions in which, without the products, the member's condition would deteriorate to the point of severe malnutrition.

(A) Enteral nutrition must be prior authorized. PA requests must include:

(i) the member's diagnosis;

(ii) the impairment that prevents adequate nutrition by conventional means;

(iii) the member's weight history before initiating enteral nutrition that demonstrates oral intake without enteral nutrition is inadequate; and

(iv) the percentage of the member's average daily nutrition taken by mouth and by tube; and

(v) prescribed daily caloric intake.

(B) Enteral nutrition products that are administered orally and related supplies are not covered.

(b) **Prior authorization requirement.** Prior authorization is the same as adults and required for all L series HCPCS codes L5000 and above.

(c) **EPSDT.** Services deemed medically necessary and allowable under federal regulations may be covered by the EPSDT Child Health program even though those services may not be part of the SoonerCare program. These services must be prior authorized.

(d) Federal regulations require OHCA to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or that are considered experimental.

317:30-5-216. Prior authorization requests

(a) Prior authorization requirements. Requirements vary for different types of services. Providers should refer to the service-specific sections of policy or the OHCA website for services requiring PA.

(1) **Required forms.** Form HCA-12A may be obtained at local county OKDHS offices and is available on the OHCA web site at www.okhca.org.

(2) **Certificate of medical necessity.** The prescribing provider must complete the medical necessity section of the CMN. This section cannot be completed by the supplier. The medical necessity section can be completed by any health care clinician; however, only the member's treating provider may sign the CMN. By signing the CMN, the physician is validating the completeness and accuracy of the medical necessity section. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the answers given in the medical necessity section of the CMN. These records may be requested by OHCA or its representatives to confirm concurrence between the medical records and the information submitted with the prior authorization request.

(3) **DIF.** The requesting supplier must complete and submit a DIF as indicated by Medicare standards unless OHCA policy indicates that a CMN or other documentation is required. By signing the DIF, the supplier is validating the information provided is complete and accurate. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the information given in the DIF.

(b) Submitting prior authorization requests. All requests for PA are submitted to OHCA, Attention: Medical Authorization Unit, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, OK 73105, or faxed to (405)530-3496 or submitted on-line via Secured Website followed by fax. All requests for prior authorization should be submitted in the same manner regardless of the age of the member.

(c) Prior authorization review. Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed by OHCA staff to evaluate whether or not each service being requested meets SoonerCare's definition of "medical necessity" [see OAC 317:30-3-1 (f)] as well as other criteria.

(d) Prior authorization decisions. After the HCA-12A is processed, a notice will be issued advising whether or not the item is authorized. If authorization is issued, the notice will include an authorization number, the time period for which the device is being

authorized and the appropriate procedure code.

(e) **Prior authorization does not guarantee reimbursement.** Provider status, member eligibility, and medical status on the date of service, as well as all other SoonerCare requirements, must be met before the claim is reimbursed.

(f) **Prior authorization of manually-priced items.** Manually-priced items must include documentation showing the supplier's estimated cost of the item with the request for prior authorization. Reimbursement will be determined as per OAC 317:30-5-218.

317:30-5-217. Billing

(a) **Procedure codes.** It is the supplier's responsibility to ensure that claims are submitted with the most appropriate procedure code for the supply or equipment. When the most appropriate procedure code is not used, the claim will be denied. When a specific procedure code has not been assigned to an item, the claim cannot be processed without a full description of the equipment or supply. An invoice is required for equipment or supplies without an assigned procedure code.

(b) **Rental.** Claims for rental should indicate the first date of service and the inclusive dates of rental as part of the description of services. The appropriate modifier must be included. Only one month's rental should be entered on each detail line.

(c) **Prior authorization number.** The prior authorization number must be submitted with the claim.

(d) **Place of service.** The appropriate indicator for the patient's place of residence must be entered.

(e) **Prescribing provider.** The name of the prescribing provider must be included for claims processing and entered in the appropriate block.

(f) Items must be received by the member before billing OHCA.

317:30-5-218. Reimbursement

(a) **Medical equipment and supplies.** Reimbursement for durable medical equipment and supplies will be made using an amount derived from the lesser of the OHCA maximum allowable fee or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established based on efficiency, economy, and quality of care as determined by the OHCA. Once the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim for proper reimbursement.

(b) **Oxygen equipment and supplies.**

(1) Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. Content for portable systems should be billed monthly with one unit equal to one month's supply. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pickup the equipment when it is no longer medically necessary.

(3) Effective July 1, 2007, payment for oxygen equipment and supplies will be based on the Medicaid allowable in effect for the Oklahoma region on June 30, 2007. The fee schedule will be reviewed annually; adjustments to the fee schedule may be made based on efficiency, budget considerations, and quality of care as determined by the OHCA.

317:30-5-547. Reimbursement

(a) Nursing services and home health aide services are covered services on a per visit basis. Reimbursement for any combination of nursing or home aid service shall not exceed 36 visits per calendar year per member. Additional visits for children must be prior authorized when medically necessary.

(b) Reimbursement for durable medical equipment and supplies will be made using the amount derived from the lesser of the OHCA fee schedule or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that OHCA will pay a provider for an allowable procedure code. When a procedure code is not assigned a maximum allowable fee for a unit of service, a fee will be established based on efficiency, economy, and quality of care as determined by the OHCA. Once the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim for proper reimbursement.

(c) Reimbursement for oxygen and oxygen supplies is as follows:

(1) Payment for oxygen systems (stationary, liquid and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are also considered continuous rental. Content for portable systems should be billed monthly with one unit equal to one month's supply. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pickup the equipment when it is no longer medically necessary.

(3) Effective July 1, 2007, payment for oxygen equipment and supplies will be based on the Medicaid allowable rates in effect for the Oklahoma region on June 30, 2007. The fee schedule will be reviewed annually; adjustments to the fee schedule may be made based on efficiency, budget considerations, and quality of care as determined by the OHCA.