
POLICY TRANSMITTAL NO. 04-02	DATE: FEBRUARY 2, 2004
FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF PLANNING, POLICY & RESEARCH

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-3-46; 30-3-57; 30-3-59; 30-5-2; 30-5-9; 30-5-11; 30-5-15; 30-5-72; 30-5-72.1; 30-5-77.2; 30-5-241; 30-5-356; 30-5-1043; 30-5-1046; 40-1-1; 317:40-5, Table of Contents; 40-5-111; 40-5-112; 40-5-153; and 40-5-154.

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

Developmental Disabilities Services rules are revised to establish guidelines for residential support services provided under the new Home and Community Based Homeward Bound Waiver for persons with developmental disabilities.

Medical Providers Fee-for-Service rules are revised to increase the monthly compensable number of outpatient physician visits for Medicaid eligible adults from two to four visits per month.

Residential Behavioral Management Services in Group Settings and Non-Secure Diagnostic and Evaluation Centers specific rules are revised establishing a system of care provided by the Organized Health Care Delivery system (OHCDs) for children in the care and custody of the Oklahoma Department of Human Services (OKDHS) and the Office of Juvenile Affairs. Other revisions incorporate the Oklahoma Board of Nursing's definition of an Advanced Practice Nurse into rules and update existing language regarding the Child in Need of Mental Health Treatment Act and Health Care Financing Agency to reflect current terminology.

Outpatient Behavioral Health Services rules are revised to: (a) comply with HIPAA national coding requirements and update compensable service titles, descriptions, and units of service which match HCPCS codes; (b) establish the Mental Health Assessment by a Non-Physician service which is compensable for clients who are seeking services for the first time from a contracted agency if the client is not receiving or previously received services from that agency; and (c) establish the Program for Assertive Community Treatment (PACT) services.

Pharmacists specific, rules are revised to remove the prior authorization requirement for smoking cessation products in order to assist Medicaid recipients with their smoking cessation efforts.

Fee-for-Service rules are revised to increase the number of compensable prescription drugs: (a) for adults, from the three prescription limitation to a total of six monthly, with a limit of three brand name drugs per month; and (b) for adults receiving services under the Home and Community Based Services Waivers, from the five prescription limitation to a total of six monthly, with a limit of three brand name drugs per month. In addition, adults receiving services under the '1915(c) Home and Community Based Services Waivers could receive up to seven additional medically necessary generic prescriptions per month. Coverage of medically necessary prescriptions beyond the three brand name or thirteen total prescriptions for this group of adult waiver recipients would be compensable when prior authorized.

Original signed on 1-31-04

Mary Stalnaker, Director
Family Support Services Division

Marilynn Knott, Administrator
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WF # 04-D

INSTRUCTIONS FOR FILING MANUAL MATERIAL

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

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, DHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, DHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Rules and Policy Management Unit staff at (405) 521-3611.

REMOVE

INSERT

317:30-3-46	317:30-3-46, pages 1-2, revised 1-01-04
317:30-3-57	317:30-3-57, pages 1-8, revised 1-01-04
317:30-3-59	317:30-3-59, pages 1-2, revised 1-01-04
317:30-5-2	317:30-5-2, pages 1-15, revised 1-01-04
317:30-5-9	317:30-5-9, pages 1-4, revised 1-01-04
317:30-5-11	317:30-5-11, 1 page only, revised 1-01-04
317:30-5-15	317:30-5-15, pages 1-2, revised 1-01-04
317:30-5-72	317:30-5-72, pages 1-2, revised 1-01-04
317:30-5-72.1	317:30-5-72.1, pages 1-3, revised 1-01-04
317:30-5-77.2	317:30-5-77.2, pages 1-4, revised 1-01-04
317:30-5-241	317:30-5-241, pages 1-12, revised 1-01-04
317:30-5-356	317:30-5-356, pages 1-2, revised 1-01-04
317:30-5-1043	317:30-5-1043, pages 1-10, revised 1-04-04
317:30-5-1046	317:30-5-1046, 1 page only, revised 1-01-04
317:40-1-1	317:40-1-1, pages 1-9, revised 1-01-04
317:40-5, Table of Contents	317:40-5, Table of Contents, pages 1-3, revised 1-1-04

REMOVE

INSERT

317:40-5-111, 1 page only, issued 11-21-03

317:40-5-112, pages 1-2, issued 1-01-04

317:40-5-153, pages 1-3, issued 11-21-03

317:40-5-154, 1 page only, issued 11-21-03

317:30-3-46. Services for persons infected with tuberculosis

(a) Oklahoma Medicaid provides optional coverage of tuberculosis (TB) related services for certain TB infected individuals. Services covered under this program are not restricted to the Medicaid scope of coverage or limitations. Services for TB infected individuals that exceed the scope of Medicaid services must be prior authorized. Individuals eligible only under the optional TB-related services program can receive TB related services such as:

(1) Prescribed medications:

(A) Prescription drugs indicated for the treatment of TB up to the Medicaid established prescription limit; and

(B) Other drugs related to the treatment of TB beyond the prescriptions covered under Medicaid, require prior authorization obtained from the University of Oklahoma College of Pharmacy using form "Petition for TB Related Therapy".

(2) Physician services:

(A) Physician services include:

(i) ambulatory physician services;

(ii) office visits; and

(iii) ambulatory surgery and such, but not including inpatient services.

(B) Office visits are not limited for TB infected persons. However, prior authorization is required when the limit under Medicaid is exceeded;

(3) Outpatient hospital services;

(4) Rural Health Clinic services;

(5) Federally Qualified Health Clinic services;

(6) Laboratory and x-ray services. Necessary laboratory and x-ray services (including services to confirm presence of TB infection) are covered for infected persons. Screening tests to

detect and confirm presence of TB do not require prior authorization;

(7) Tuberculosis Clinic services (See 317:30-5-911 for description of these services); and

(8) Targeted Case Management services (See 317:30-5-921 for a description of these services).

(b) Persons eligible for services only under optional TB coverage do not receive the full range of Medicaid benefits. Coverage is limited as set out in this Section.

(c) Persons eligible under Medicaid who are infected with TB may also be eligible for TB services and receive these extended benefits.

317:30-3-57. General Medicaid coverages - categorically needy

The following are general Medicaid coverages for the categorically needy:

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

(A) Adult coverage limited to the compensable inpatient hospital days described at OAC 317:30-5-41.

(B) Coverage for persons 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 the Authority.

(6) Outpatient Mental Health Services for medical and remedial care including services provided on an outpatient basis by certified hospital based facilities who 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 through the Oklahoma State Health Department.

(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided adults, not specifically addressed, are covered only when prior authorized by the agency's Medical

Authorization Unit.

(11) One screening mammogram and one follow-up mammogram every year for women beginning at age 30. Additional follow-up mammograms are covered when medically necessary. Additional follow-up mammograms require a prior authorization from the agency's Medical Authorization Unit.

(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 each eligible individual 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 will require prior authorization. EPSDT services include payment for:

(A) Child health screening examinations for eligible children by a medical or osteopathic physician.

(i) Scheduled screenings include:

(I) six screenings during the first year of life

(II) two screenings in the second year;

(III) one screening yearly for ages 2 thru 5 years; and

(IV) one screening every other year for ages 6 thru 20 years.

(ii) Interperiodic screenings outside the periodicity schedule for screening examinations are allowed at necessary intervals when a medical condition is suspected.

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

(C) Immunizations.

(D) Outpatient care.

(E) Dental services, including inpatient services in an eligible participating hospital, outpatient dental screening every 12 months, two bite wing x-rays, and/or oral prophylaxis one each 12 months; emergency services for relief of pain and/or acute infection; limited restoration, repair and/or replacement of dental defects after the treatment plan submitted by dentist has been authorized.

(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 include hearing evaluation at least once every 12 months, hearing aid evaluation if indicated and purchase of a hearing aid when prescribed by a state licensed audiologist who holds a certificate of clinical competence from the American Speech and Hearing Association and preauthorized. Interperiodic hearing examinations are allowed at intervals outside the periodicity schedule when a hearing condition is suspected.

(H) Prescribed drugs.

(I) Outpatient Psychological services for eligible individuals under 21 years of age must be prior authorized. Payment is made to eligible psychologists who are duly licensed to practice. Outpatient testing and diagnosis is limited to one hour per patient each 12 months. Additional hours may be prior authorized.

(J) Inpatient Psychotherapy Services. Payment is made to eligible psychologists and psychiatrists. Inpatient psychotherapy by a psychologist must be prior authorized.

(K) Inpatient psychological testing for eligible individuals under 21 years of age. Limited to one hour per recipient

each 12 months. If medically necessary, additional hours must be prior authorized. Payment is made to eligible psychologists who are duly licensed to practice.

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

(M) Inpatient hospital services.

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

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

(14) Family planning services and supplies for individuals of child-bearing age, including counseling, insertion of intrauterine device and sterilization for persons 21 years of age and over 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 are not covered. Reversal of sterilization procedures may be covered when medically indicated and substantiating documentation is attached to the claim. The Norplant System for birth control is covered; however, removal of the Norplant System prior to five years is covered only when documented as medically necessary. Reinsertion of Norplant contraceptive will be considered on a case by case basis.

(15) Family planning centers.

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

(17) Medical care and any other type of remedial care recognized

under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. See applicable provider section for limitations to covered services for:

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

(18) Free-standing ambulatory surgery centers.

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

(A) unlimited medically necessary monthly prescriptions for:

(i) individuals under the age of 21 years; and

(ii) residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded.

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

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

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

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

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

(24) Standard medical supplies.

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

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

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

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

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

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

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

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

(33) Personal care in recipient's home, prescribed in accordance with a plan of treatment and rendered by a qualified person

under supervision of an R.N.

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

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

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

(37) Organ and tissue transplantation services for children and adults, limited to bone marrow, stem cells, cornea, heart, kidney, liver, lung, SPK (simultaneous pancreas kidney), PAK (pancreas after kidney), and heart-lung, are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) All transplantation services, 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 Medicaid program all organ transplants must be performed at a Medicare approved transplantation center.

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

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

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

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

(41) Services delivered in Federally Qualified Health Centers. Payment will be made on an encounter basis. An encounter is all medical or dental services provided by the center in one day.

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

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

(44) Birthing center services.

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

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

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

317:30-3-59. General program exclusions - adults

The following are excluded from Medicaid coverage for adults:

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

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

(3) Services of two physicians for the same type of service to the same patient at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the patient's care, the codes for subsequent hospital care should be used.

(4) Refractions and visual aids.

(5) Separate payment for pre and post-operative care when payment is made for surgery.

(6) Reversal of sterilization procedures for the purposes of conception.

(7) Treatment for obesity.

(8) Non therapeutic hysterectomies. Therapeutic hysterectomies require that the following information to be attached to the claim:

(A) a copy of an acceptable acknowledgment form signed by the patient, or,

(B) an acknowledgment by the physician that the patient has already been rendered sterile, or,

(C) a physician=s certification that the hysterectomy was performed under a life-threatening emergency situation.

(9) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest.

(10) Medical services considered to be experimental.

(11) Services of a Certified Surgical Assistant.

(12) Services of a Chiropractor. Payment is made for Chiropractor services on Crossover claims for coinsurance and/or deductible only.

(13) Services of a Registered Physical Therapist.

(14) Services of a Psychologist.

(15) Services of a Speech and Hearing Therapist.

(16) Physician and hospital services in a general acute care hospital beyond the 24 day compensable hospital period per person per State fiscal year.

(17) Payment for more than four outpatient visits per month (home, office, outpatient hospital) per patient, except those visits in connection with family planning or emergency medical condition.

(18) Payment for more than two nursing home visits per month.

(19) More than one inpatient visit per day per physician.

317:30-5-2. General coverage by category

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Authority's medical programs, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services may be based on a determination made by the medical consultant in individual circumstances.

(1) Coverages include the following:

(A) Effective August 1, 2000, all general acute care inpatient hospital services for all persons 21 years of age or older, will be limited to 24 days per person per state fiscal year (July 1 through June 30). This limitation does not apply to free-standing psychiatric facilities providing inpatient treatment to persons under 21 years of age and 65 years of age and older. The 24 days limitation applies to both hospital and physician services. Payment will be made for up to 24 hospital days paid on hospital claims during a state fiscal year for each individual recipient. These days will be maintained on the recipient record. Physician claims for hospital visits will be paid until the last compensable hospital day is captured. After 24 hospital days have been captured, no inpatient physician services will be paid beyond the last compensable hospital day. No exceptions or extensions will be made to the 24 day inpatient services limitation. All inpatient services are subject to post-payment review by the OHCA, or its designated agent. Effective October 1, 1993, for all persons ages 21 to 65 years, there is no coverage for inpatient chemical dependency treatment and inpatient detoxification is limited to a maximum of five days per admission and subject to post payment review.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgicenter or a Medicare certified hospital that offers outpatient surgical services.

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OAC 317:30-5-2 (p2)

Refer to the List of Covered Surgical Procedures.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections.

(G) Direct physicians' services are covered on an outpatient basis. A maximum payment of four visits are covered per month per patient in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.

(H) Direct physicians' services in a nursing facility for those patients approved for nursing care. Payment is made for a maximum of two nursing facility visits per month. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/Medicaid patient, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

(I) Payment is made for medically necessary diagnostic x-ray and laboratory work.

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

(K) Obstetrical care.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure. Payment is made based upon an invoice for the item.

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs under the jurisdiction of the Authority. A copy of the authorization, DHS form ABCDM-16, Authorization for Examination and Billing, must accompany the claim.

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OAC 317:30-5-2 (p3)

(N) If a physician personally sees a patient on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.

(O) Family planning - including sterilization procedures for legally competent persons 21 years of age and over who voluntarily request such a procedure and, with their physician, execute the Federally mandated consent form (ADM-71). A copy of the consent form must be attached to the claim form. Separate payment is made for an I.U.D. inserted during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception are not covered. Reversal of sterilization procedures may be covered when medically indicated and substantiating documentation is attached to the claim. The Norplant System for birth control is covered; however, removal of the Norplant System prior to five years is covered only when documented as medically necessary. Reinsertion of Norplant contraceptive will be considered on a case by case basis.

(P) Genetic counseling (requires special medical review prior to approval).

(Q) Blood count weekly for persons receiving the drug Clozaril.

(R) Complete blood count and platelet count prior to receiving chemotherapeutic agents or radiation therapy and for persons receiving medication such as DPA-D-Penacillamine on a regular basis for treatment other than malignancies.

(S) Payment of ultrasounds for pregnant women as specified in OAC 317:30-5-22.

(T) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the patient in conformity with Federal regulations.

(U) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:

(i) Recognition as clinical faculty with participation in

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OAC 317:30-5-2 (p4)

such activities as faculty call, faculty meetings, and having hospital privileges;

(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;

(iii) Hold unrestricted license to practice medicine in Oklahoma;

(iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;

(v) Seeing patients without supervision;

(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;

(vii) Submit billing in own name with appropriate Oklahoma Medicaid provider number.

(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.

(V) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.

(i) Attending physician performs chart review and sign off on the billed encounter;

(ii) Attending physician present in the clinic/or hospital setting and available for consultation;

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(W) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:

(i) The patient must be at least minimally examined and

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OAC 317:30-5-2 (p5)

reviewed by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) This contact must be documented in the medical record.

(X) Payment to a physician for supervision of CRNA services unless the CRNA bills directly.

(Y) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.

(Z) Organ and tissue transplantation services for children and adults, limited to bone marrow, stem cells, cornea, heart, kidney, liver, lung, SPK (simultaneous pancreas kidney), PAK (pancreas after kidney), and heart-lung, are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

(i) All transplantation services, except kidney and cornea, must be prior authorized to be compensable.

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

(iii) To be compensable under the Medicaid program all organ transplants must be performed at a Medicare approved transplantation center.

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

(AA) Total parenteral nutritional therapy for certain diagnoses and when prior authorized.

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) Ambulatory services for treatment of persons with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB not listed in OAC 317:30-3-46 require prior

authorization by the University of Oklahoma College of Pharmacy using form "Petition for TB Related Therapy". Ambulatory services to persons infected with TB are not limited to the scope of the Medicaid program, but require prior authorization when the scope is exceeded.

(2) General exclusions include the following:

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

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

(C) Services of two physicians for the same type of service to the same patient at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the patient's care, the codes for subsequent hospital care should be used.

(D) Refractions and visual aids.

(E) Separate payment for pre and post-operative care when payment is made for surgery.

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of persons who are under 21 years of age, mentally incompetent or institutionalized. Reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomy.

(I) Medical services considered to be experimental or investigational.

(J) Payment for more than four outpatient visits per month

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OAC 317:30-5-2 (p7)

(home or office) per patient except those visits in connection with family planning, or related to emergency medical conditions.

(K) Payment for more than two nursing facility visits per month.

(L) More than one inpatient visit per day per physician.

(M) Physician supervision of hemodialysis or peritoneal dialysis.

(N) Physician services which are administrative in nature and not a direct service to the patient including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.

(O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(P) Payment for the services of physicians' assistants, social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out.

(Q) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (See OAC 317:30-5-6 or 317:30-5-50.)

(R) Night calls or unusual hours.

(S) Speech and Hearing services.

(T) Treatment for obesity, including weight reduction surgery.

(U) Mileage.

(V) Other than routine hospital visit on date of discharge unless patient expired.

**MEDICAL PROVIDERS-FEE FOR SERVICE
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OAC 317:30-5-2 (p8)

(W) Direct payment to perfusionist as this is considered part of the hospital cost.

(X) Inpatient chemical dependency treatment.

(Y) Fertility treatment.

(Z) Routine immunizations.

(b) **Children.** Payment is made to physicians for medical and surgical services for persons under the age of 21 within the scope of the Authority's medical programs, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for patients under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services will be prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services will not be Medicaid compensable.

(A) Effective October 1, 1993, all residential and acute psychiatric services will be authorized based on the medical necessity criteria as described in OAC 317:30-5-46.

(B) Out of state placements will not be authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for recipients in a particular border locality to use resources in another state. If a medical emergency occurs while a client is out of the state, treatment for medical services will be covered in the same way as they would be covered within the state. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for persons under the age of 21 are not limited. All inpatient care must be

medically necessary.

(3) Procedures for requesting extensions for inpatient services.

The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options.

(A) Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation which validates the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-46. Requests shall be made prior to the expiration of the approved inpatient stay.

(B) If a denial decision is made, a reconsideration request may be made directly to the OHCA, or its designated agent and should occur within 3 days of the denial notification due to the timeliness of processing such a request with the patient still in the facility. The request for reconsideration shall include new and/or additional medical information to justify the need for continued care.

(4) Utilization control requirements for psychiatric beds.

Medicaid utilization control requirements for inpatient psychiatric services for persons under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) Early and periodic screening diagnosis and treatment program.

Payment is also made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of individuals under age 21. The EPSDT program is a comprehensive child health program, designed for ensuring the availability of and access to required health care resources and helping parents and guardians of Medicaid eligible children effectively use these resources. An effective EPSDT program assures that health problems found are diagnosed and treated early before they become more complex and their treatment more costly. The physician plays a significant role in educating parents and guardians in all services available through the EPSDT program. The receipt of an identified EPSDT screening makes the Medicaid child eligible for all necessary follow-up care that is within the scope of the Medicaid Program. Federal regulations also

require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the Authority's current program. Such services must be allowable under the Federal Regulations. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and will require prior authorization. The following services are covered under EPSDT:

(A) The Oklahoma Program adopted the following recommendations which includes at least:

- (i) Six screenings during the first year of life;
- (ii) Two screenings in the second year;
- (iii) One screening yearly for ages two thru five years;
and
- (iv) One screening every other year for ages 6 thru 20 years.

(B) Periodicity schedules for screening, dental, vision and hearing, and other services include:

(i) **Screening services.** Comprehensive examinations performed by a licensed physician, dentist or other provider qualified under State law to furnish primary medical and health services are covered. See OAC 317:30-3-47 for EPSDT services. Screenings must include all of the following:

- (I) A comprehensive health and developmental history (including assessment of both physical and mental health development);
- (II) A comprehensive unclothed physical exam;
- (III) Appropriate immunizations according to age and health history;
- (IV) Laboratory tests (including lead blood level assessment appropriate to age and risk); and
- (V) Health education (including anticipatory guidance).

(ii) **Vision services.** At a minimum, vision services include diagnosis and treatment for defects in vision, including eyeglasses. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal.

(iii) **Dental services.** At a minimum, dental services include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services. Coverage also includes inpatient services in an eligible participating hospital, outpatient dental screening every 12 months, two bite-wing x-rays, and/or oral prophylaxis one each 12 months; other restoration, repair and/or replacement of dental defects after the treatment plan submitted by a dentist has been authorized. This includes amalgam and composite restoration, pulpotomies, chrome steel crowns, anterior root canals, pulpectomies, band and loop space maintainers, cement bases, acrylic flippers, and lingual arch bars. (Refer to Dental Provider Manual for limitations.)

(iv) **Hearing services.** At a minimum, hearing services include diagnosis and treatment for defects in hearing, including hearing aids. Hearing aid evaluation once every 12 months and purchase of a hearing aid when prescribed as a result of the hearing aid evaluation.

(v) **Immunizations.** Federal legislation created the Vaccine for Children Program to be effective October 1, 1994. Vaccines will be provided free of charge to all enrolled providers for Medicaid eligible children. Participating providers may bill for an administration fee to be set by HCFA on a regional basis. They may not refuse to immunize based on inability to pay the administration fee. Medicaid will continue to pay non-participating providers for vaccines and an administration fee of \$2.10 until April 1, 1995, when Federal Financial Participation will no longer be available.

(vi) **Appropriate laboratory tests.** Use medical judgement in determining the applicability of the laboratory tests or analyses to be performed. If any laboratory tests or analyses are medically contraindicated at the time of the

screening, provide them when no longer medically contraindicated laboratory tests should only be given when medical judgement determines they are appropriate. However, laboratory tests should not be routinely administered.

(I) As appropriate, conduct the following laboratory tests: Anemia test; Sickle cell test. If a child has been properly tested once for sickle cell disease, the test need not be repeated. Tuberculin test. Give a tuberculin test to every child who has not received one within a year.

(II) Lead toxicity screening. Where age and risk factors indicate it is medically appropriate to perform a blood level assessment, a blood level assessment is mandatory. See OAC 317:30-3-50 for required lead screening guidelines.

(vii) **Other necessary health care.** Other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

(I) Interperiodic screenings outside the periodicity schedule for screening examinations are allowed at necessary intervals when a medical condition is suspected.

(II) Outpatient care for acute physical injury.

(III) Prescribed drugs beyond the prescription limitation.

(IV) Inpatient psychotherapy for individuals under 21 years of age when prior authorized. Payment is made to psychologists who are licensed to practice.

(V) Inpatient psychological testing. Limited to one hour per recipient each 12 months. If medically necessary, additional hours will be prior authorized. Payment is made to psychologists who are licensed to practice.

(VI) Outpatient psychological services for eligible individuals under 21 years of age when prior authorized. See (V) of this unit for limitations.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Title 21, Oklahoma Statutes, Section 846, as amended, states in part: *Every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic physicians, residents, and interns, examining, attending, or treating a child under the age of eighteen (18) years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of eighteen (18) years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above. Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought as a result of the report.*

(7) **General exclusions.** The following are excluded from coverage for persons under the age of 21:

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

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same patient at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising

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on a new plan of care in response to changes in the patient's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the patient's care, the codes for subsequent hospital care should be used.

(D) Separate payment for pre and post-operative care when payment is made for surgery.

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of persons who are under 21 years of age.

(G) Non-therapeutic hysterectomy.

(H) Medical Services considered to be experimental or investigational.

(I) More than one inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (See OAC 317:30-5-6 or 317:30-5-50.)

(K) Physician supervision of hemodialysis or peritoneal dialysis.

(L) Physician services which are administrative in nature and not a direct service to the patient including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.

(M) Payment for the services of physicians' assistants except as specifically set out.

(N) Direct payment to perfusionist as this is considered part of the hospital cost.

(O) Treatment of obesity including weight reduction surgery.

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(P) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(Q) Night calls or unusual hours.

(R) Mileage.

(S) Other than routine hospital visit on date of discharge unless patient expired.

(T) Tympanometry.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. For in-State physicians, claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits will reflect a message that the claim was referred to Medicaid. If such a message is not present, a claim for coinsurance and deductible must be filed with Medicaid within 90 days of the date of Medicare payment in order to be considered timely filed. The Medicare EOMB must be attached to the claim. If payment was denied by Medicare Part B, and the service is a Medicaid covered service, mark the claim "denied by Medicare".

(1) Out of state claims will not "cross over". Providers must file a claim for coinsurance and/or deductible within 90 days of the Medicare payment. The Medicare EOMB must be attached to the claim.

(2) Claims filed under Medicaid must be filed within one year from the date of service. For dually eligible individuals, to be eligible for payment of coinsurance and/or deductible under Medicaid, a claim must be filed with Medicare within one year from the date of service.

317:30-5-9. Medical services

(a) **Use of medical modifiers.** The Physicians' Current Procedural Terminology (CPT) and the second level HCPCS provide for 2-digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

(1) Payment is made for four office visits (or home) per month per patient, for adults (over age 21), regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.

(2) Visits for the purpose of family planning are excluded from the four per month limitation.

(3) Payment is allowed for insertion of IUD in addition to the office visit.

(4) Separate payment will be made for the following supplies when furnished during a physician's office visit.

(A) Casting materials

(B) Dressing for burns

(C) Intrauterine device

(D) IV Fluids

(E) Medications administered by IV

(F) Glucose administered IV in connection with chemotherapy in office

(5) Payment is made for routine physical exams only as prior authorized by the County DHS office and are not counted as an office visit.

(6) Medically necessary office lab and X-rays are covered.

(7) Hearing exams by physician for persons between the ages of 21 and 65 are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.

(8) Hearing aid evaluations are covered for persons under 21 years of age.

(9) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.

(10) Payment is made for both office visit and injection of joints performed during the visit.

(11) Payment is made for an office visit in addition to allergy testing.

(12) Separate payment is made for antigen.

(13) Eye exams are covered for persons between ages 21 and 65 for medical diagnosis only.

(14) If a physician personally sees a patient on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.

(15) The following specimen collection fees are covered:

(A) Catheterization for collection of specimen, multiple patients.

(B) Catheterization for collection of specimen, single patient, all places of service.

(C) Routine Venipuncture.

(16) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.

(17) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.

(c) Non-covered office services.

(1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.

(2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.

(3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.

(4) Additional payment will not be made for night calls, unusual hours or mileage.

(5) Payment is not made for an office visit where the patient did not keep appointment.

(6) Refractive services are not covered for persons between the ages of 21 and 65.

(7) Removal of stitches is considered part of post-operative care.

(8) Payment is not made for a consultation in the office when the physician also bills for surgery.

(9) Separate payment is not made for oxygen administered during an office visit.

(d) Covered inpatient medical services.

(1) For persons between ages 21 and 65, payment is made for 24 days hospital care per state fiscal year. For persons under 21 years of age, payment is made for medically necessary inpatient care. Psychiatric admissions must be prior authorized.

(2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient=s status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the patient=s care, the codes for subsequent hospital care should be used.

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(3) Certain medical procedures are allowed in addition to office visits.

(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day and 4 units per month. Payment for critical care, each additional 30 minutes is limited to two units per day/month.

(e) Non-covered inpatient medical services.

(1) For inpatient services, all visits to a patient on a single day are considered one service except where specified. Payment is made for only one visit per day.

(2) A hospital admit or visit and surgery on the same day would not be covered if post-operative days are included in the surgical procedure. If there are no post-operative days, a physician can be paid for visits.

(3) Drugs administered to inpatients are included in the hospital payment.

(4) Payment will not be made to a physician for an admission or new patient work-up when patient receives surgery in out-patient surgery or ambulatory surgery center.

(5) Payment is not made to the attending physician for interpretation of tests on his own patient.

(f) Other medical services.

(1) Payment will be made to physicians providing Emergency Department services.

(2) Payment is made for two nursing home visits per month. The appropriate CPT code should be used.

(3) When payment is made for "Evaluation of arrhythmias" or "Evaluation of sinus node", the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.

(4) When the physician bills twice for the same procedure on the same day, it should be supported by a written report.

317:30-5-11. Psychiatric services

On codes where time is specified, the physician must report individual psychotherapy to the patient for that specified amount of time. Payment is made for the following services:

(1) Individual Psychotherapy: Individual Psychotherapy is covered on an inpatient or outpatient basis. Outpatient psychotherapy is subject to the four outpatient visits per month limitation. Individual psychotherapy (doctor to patient) is defined as a service personally rendered to an individual by a physician.

(2) Family therapy: Family Therapy must be for the direct benefit of the identified patient even when provided without the patient present.

(3) Psychological testing by physician.

317:30-5-15. Chemotherapy injections

(a) Outpatient.

(1) Outpatient chemotherapy is compensable only when a malignancy is indicated or for the diagnosis of Acquired Immune Deficiency Syndrome (AIDS). Outpatient chemotherapy treatments are unlimited. Outpatient visits in connection with chemotherapy are limited to four per month.

(2) Payment for administration of chemotherapy medication is made under appropriate HCPC Supplemental J Codes. Payment is made separately for office visit and administration under the appropriate CPT code.

(3) When injections exceed listed amount of medication, show units times appropriate quantity, i.e., injection code for 100 mgm but administering 300, used 100 mgm times 3 units.

(4) Glucose - fed through IV in connection with chemotherapy administered in the office would be covered.

(b) Inpatient.

(1) Inpatient hospital supervision of chemotherapy administration is non-compensable. The hospital visit in connection with chemotherapy could be allowed within our guidelines if otherwise compensable, but must be identified by description.

(2) Hypothermia - Local hypothermia is compensable when used in connection with radiation therapy for the treatment of primary or metastatic cutaneous or subcutaneous superficial malignancies. It is not compensable when used alone or in connection with chemotherapy.

(3) The following are not compensable:

(A) Chemotherapy for Multiple Sclerosis;

(B) Efudex;

(C) Oral Chemotherapy;

(D) Photochemotherapy;

- (E) Scalp Hypothermia during Chemotherapy; and
- (F) Strep Staph Chemotherapy.

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

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

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

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

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

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

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

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

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

317:30-5-72.1. Drug benefit

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

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

(A) Agents used to promote fertility.

(B) Agents primarily used to promote hair growth.

(C) Agents used for cosmetic purposes.

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

(E) Vitamins and Minerals.

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

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

(H) Food supplements.

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Male and Female Condoms.

(ii) Contraceptive sponges.

(iii) Diaphragms.

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

(3) All covered outpatient drugs are subject to prior

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

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

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

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

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

317:30-5-77.2. Prior authorization

(a) **Definition.** The term prior authorization means an authorization by OHCA to the pharmacist to fill the prescription before it is filled by the pharmacist.

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

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

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

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

(1) **Utilization.**

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

(B) **Duration.**

(i) **H2 antagonists/proton pump inhibitors/carafate.** H2 receptor antagonists and Carafate are covered for eligible individuals for 90 days of therapy in the previous 360 days. H2 antagonists and Carafate do not require prior authorization when prescribed at the recommended doses or lower after the 90 day limit. The following are recommended doses for these drugs.

(I) Drug name: Ranitidine (Zantac): 300mg per day

(II) Drug name: Cimetidine (Tagamet): 800mg per day

(III) Drug name: Famotidine (Pepcid): 20mg per day

(IV) Drug name: Nizatidine (Axid): 150mg per day

(V) Drug name: Sucralfate (Carafate): 1000mg four times per day

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

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

(iv) **Hypnotics.** Ambien a hypnotic medication similar in activity to benzodiazepines is covered for eligible individuals for 90 days of therapy in the previous 360 days. Prior authorization is required when additional coverage is medically necessary beyond this limit.

(2) **Scope.**

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

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

- (i) the treatment of short stature, Turner=s syndrome, hypoglycemia related growth hormone deficiency;
- (ii) physiologic replacement for adults who previously met growth hormone deficiency guidelines as children; and
- (iii) catabolic wasting in AIDS patients.

(C) **Anorexiant.** Limited anorexiant coverage is available for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) and Narcolepsy. All products require prior authorization for use in adults. The anorexiants are divided into three categories. The first category requires no prior authorization for children and includes Methylphenidate immediate and controlled release formulations, Dextroamphetamine immediate and controlled release formulations, and the immediate release formulation of AdderallJ, including generic equivalents. The second category requires a prior authorization for children and adults and also requires a previous trial with both Methylphenidate and Dextroamphetamine. The products in this category are Pemoline and Methamphetamine. The third category includes Concerta, Metadate CD, and Adderall XR. These drugs require prior authorization for children and adults and a previous trial with a medication from the first category. The prescribing physician must complete and sign the petition for prior authorization. Authorizations will be

issued for a one year period.

(D) **TB related medications.** Drugs prescribed for the treatment of TB related morbidities not listed in OAC 317:30-3-46 require prior authorization.

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

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

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OUTPATIENT BEHAVIORAL HEALTH
SERVICES SPECIFIC**

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317:30-5-241. Coverage for adults and children

(a) **Service descriptions and conditions.** Outpatient behavioral health services are covered for adults and children as set forth in this Section, unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified mental health and/or substance abuse disorder(s). All services are to be for the goal of improvement of functioning, independence, or well being of the client. The client must be able to actively participate in the treatment. Active participation means that the client must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment. The assessment must include a DSM multi axial diagnosis completed for all five axes from the most recent DSM version. All services will be subject to medical necessity criteria. For DMHSAS Contracted and Private facilities, an agent designated by the Oklahoma Health Care Authority will apply the medical necessity criteria. For public facilities (regionally based CMHCS), the medical necessity criteria will be self-administered. Non prior authorized services will not be Medicaid compensable with the exception of Mental Health Assessment by a Non-Physician, Mental Health Service Plan Development, Crisis Intervention Services (by a MHP and Facility based), and Program of Assertive Community Treatment Services (PACT). Payment is not made for Outpatient Behavioral Health Services for children who are receiving Residential Behavioral Management Services in a Group Home or Therapeutic Foster Care with the exception of Psychotherapy services which must be authorized by the OHCA or its designated agent as medically necessary and indicated, and Crisis Intervention Services (facility based). Residents of nursing facilities are not eligible for Outpatient Behavioral Health services.

(1) Mental Health Assessment by a Non-Physician includes a history of psychiatric symptoms, concerns and problems, an evaluation of mental status, a psychosocial and medical history, a full five axes diagnosis and evaluation of current functioning, and an evaluation and assessment of alcohol and other drug use (historic and present). It must also include an evaluation of the client's strengths and information regarding the client's treatment preferences. For adults, it may include interviews or communications with family, caretakers, or other support persons as permitted by the client. For children under the age of 18, it must include an interview with a parent, or

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other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an MHP. The minimum face-to-face time spent in assessment with the client and others as identified previously in this paragraph for a low complexity Mental Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more. This service is compensable on behalf of a client who is seeking services for the first time from the contracted agency and is not compensable if the client has previously received or is currently receiving services from the agency.

(2) **Mental Health Services Plan Development by a Non-Physician (moderate complexity).** Mental Health Services Plan Development by a Non-Physician (moderate complexity) is to be performed by the practitioners and others who will comprise the treatment team. It is performed with the direct active participation of the client and a client support person or advocate if requested by the client. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. The Mental Health Services Plan is developed based on information obtained in the mental health assessment and includes the evaluation of assessment by the practitioners and the client of all pertinent information. It includes a discharge plan. It is a process whereby an individualized rehabilitation plan is developed that addresses the client's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited. For adults, it must be focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. Each type of service to be received must be delineated in the service plan and the practitioner who will be providing and responsible for each service must be identified. In addition, the anticipated frequency of each type of service must be included. This service is provided by the client treatment team. This includes all staff responsible for the treatment services delineated in the plan, the client (if over age 14), and the parent/guardian if under age 18. The service plan is not valid until it is signed and dated by the responsible MHP, the treating physician,

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the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met. Each signature must have the date written by the signing party on the date of signing. One unit per Medicaid recipient per provider is allowed without prior authorization. If determined by OHCA or its designated agent, one additional unit per year may be authorized.

(3) Mental Health Services Plan Development by a Non-Physician (low complexity). Mental Health Services Plan Development by a Non-Physician (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services Plan. All elements of the plan must be reviewed with the client and treatment progress assessed. When significant progress toward recovery and the treatment goals is not occurring, the service plan must be altered in order to support and maximize progress toward recovery. When significant progress has been made, the plan must be updated to reflect the improved client's abilities and strengths and services adjusted accordingly. Mental Health Services Plan Development by a Non-Physician (low complexity) will be provided by the treatment team members. The review is not valid until signed and separately dated by the responsible MHP, the responsible physician (if client is receiving medication or otherwise under the care of the physician), the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met.

(4) Individual/Interactive Psychotherapy.

(A) Individual Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change.

(B) Interactive Psychotherapy is generally furnished to children and involves the use of physical aids and nonverbal

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communication to overcome barriers to the therapeutic interaction between the clinician and the client who has not yet developed or who has lost either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician. It may be used for adults who are hearing impaired and require the use of a language interpreter due to language barriers.

(C) There are a total of six different compensable units of individual/interactive psychotherapy, three each for interactive and individual psychotherapy. They are Individual Insight Oriented, Behavior Modifying and or Supportive Psychotherapy in an Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes), and Interactive Psychotherapy in an office or Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes). There is a maximum of one unit of either Individual or Interactive Psychotherapy per day. With the exception of a qualified interpreter if needed, only the client and the MHP should be present and the setting must protect and assure confidentiality. Ongoing assessment of the client's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the client's developmental and cognitive abilities.

(D) Individual/Interactive counseling must be provided by a MHP.

(5) Group Psychotherapy.

(A) Group Psychotherapy is a method of treating behavioral disorders using the interaction between the MHP and two or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual client's current service plan. This service does not include social or daily living skills development as described under Individual and Group Psychosocial Rehabilitation Services.

(B) Group Psychotherapy must take place in a confidential setting limited to the MHP conducting the service, an assistant or co-therapist, if desired, and the group

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psychotherapy participants. Group Psychotherapy is limited to a total of eight adult individuals except when the individuals are residents of an ICF/MR where the maximum group size is six. For all children under the age of 18, the total group size is limited to six. The typical length of time for a group psychotherapy session is one hour. A maximum of two Group Psychotherapy units per day are allowed. Half units are acceptable. The individual client's behavior, the size of the group, and the focus of the group must be included in each client's medical record. A group may not consist solely of related individuals.

(C) Group psychotherapy will be provided by a MHP.

(6) Family Psychotherapy.

(A) Family Psychotherapy is a face-to-face psychotherapeutic interaction between a MHP and the client's family, guardian, and/or support system. It is typically inclusive of the identified client, but may be performed if indicated without the client's presence. When the client is an adult, his/her permission must be obtained. Family psychotherapy must be provided for the direct benefit of the Medicaid recipient to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting.

(B) The length of a Family Psychotherapy session is one hour. No more than two hours of Family Psychotherapy are allowed per day. Half units are acceptable. Family Psychotherapy must be provided by a MHP.

(7) Psychosocial Rehabilitation Services (group).

(A) Psychosocial Rehabilitation Services are behavioral health remedial services which are necessary to improve the client's ability to function in the community. They are performed to improve the skills and abilities of clients to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. This service may take the form of a psychosocial clubhouse and promote the principles and practices of a work ordered day. Compensable Psychosocial Rehabilitation Services are provided to clients who have the ability to

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benefit from the service. The services performed must have a purpose that directly relates to the goals and objectives of the client's current service plan. A client who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.

(B) Travel time to and from Psychosocial Rehabilitative treatment is not compensable. Breaks, lunchtime and times when the client is unable or unwilling to participate are not compensable. The minimum staffing ratio is fourteen clients for each BHRS or MHP for adults and eight to one for children under the age of eighteen. Countable professional staff must be appropriately trained in a recognized anger behavioral/management intervention program such as MANDT or CAPE. This service may be performed by a BHRS using a curriculum approved by a licensed MHP clinician. In order to develop and improve the client's community and interpersonal functioning and self care abilities, rehabilitation may take place in settings away from the Outpatient Behavioral Health agency site. When this occurs, the BHRS or MHP must be present and interacting, teaching, or supporting the defined learning objectives of the client for the entire claimed time. The service is a fifteen minute time frame and may be billed up to a maximum of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing transportation for recipients who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. The OHCA transportation program will arrange for transportation for those who require specialized transportation equipment. Residents of an ICF/MR or children receiving Residential Behavioral Management Services in a Group or Therapeutic Foster Care setting are not eligible for this service.

(C) Group Psychosocial Rehabilitation Services are provided utilizing a treatment curriculum approved by a MHP. A BHRS or MHP may perform group psychosocial rehabilitation services.

(8) Psychosocial Rehabilitation Services (individual).

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(A) Psychosocial Rehabilitation Services (individual) is performed for the same purposes and under the same description and requirements as Psychosocial Rehabilitation Services (group) [Refer to paragraph (7) of this subsection]. It is generally performed with only the client present, but may include the client's family or support system in order to educate them about the rehabilitative activities, interventions, goals and objectives.

(B) A BHRS or MHP must provide this service. Residents of ICF/MR facilities and children receiving Residential Behavioral Management Group services in a Foster or Home setting are not eligible for this service. This billing unit is fifteen minutes and no more than six units per day are compensable.

(9) Psychological testing.

(A) Psychological testing is provided by a psychologist utilizing tests selected from currently accepted psychological test batteries. Test results must be reflected in the Mental Health Services plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) Psychological testing will be provided by a psychologist or certified psychometrist. A psychological technician of a psychologist may provide psychological testing.

(10) Medication Training and Support.

(A) Medication Training and Support is a documented review and educational session by a registered nurse, or physician's assistant focusing on a client's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the client on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization. Medication Training and Support may not be billed for Medicaid recipients who reside in ICF/MR facilities.

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(B) Medication Training and Support must be provided by a licensed registered nurse, or a physician's assistant as a direct service under the supervision of a physician.

(11) Crisis Intervention Services.

(A) Crisis Intervention Services are for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal or severe psychiatric distress. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented. Crisis Intervention Services are not compensable for Medicaid recipients who reside in an ICF/MR, or who receive Residential Behavioral Management Services in a Group or Therapeutic Foster home, or recipients who, while receiving other behavioral health services, experience acute behavioral or emotional dysfunction. The unit is a fifteen minute unit with a maximum of eight units per month and 40 units each 12 months per recipient.

(B) Crisis Intervention Services must be provided by a MHP.

(12) Crisis Intervention Services (facility based stabilization). Crisis Intervention Services (facility based stabilization) are emergency psychiatric and substance abuse services to resolve crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical assessment. Crisis Intervention Services (facility based stabilization) will be under the supervision of a physician aided by a licensed nurse, and will also include mental health professionals for the provision of group and individual treatments. A physician must be available. This service is limited to providers who contract with or are operated by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) to provide this service within the overall behavioral health service delivery system. Crisis Intervention Services (facility based stabilization) are compensable for child and adult Medicaid recipients. Only children who are enrolled and approved through a Community Based Systems of Care Program are eligible for this service. The unit of service is per hour. The ODMHSAS is responsible for

providing the State match for this service.

(13) Program of Assertive Community Treatment (PACT) Services.

(A) Program of Assertive Community Treatment (PACT) Services are those delivered within an assertive community based approach to provide treatment, rehabilitation, and essential behavioral health supports on a continuous basis to individuals 18 years of age or older with serious mental illness with a self contained multi-disciplinary team. The team must use an integrated service approach to merge essential clinical and rehabilitative functions and staff expertise. This level of service is to be provided only for persons most clearly in need of intensive ongoing services. Services must satisfy all statutory required program elements as articulated in the Oklahoma Administrative Code 450:55. At a minimum, the services must include:

(i) Assessment and evaluation;

(ii) Crisis intervention to cover psychiatric crisis and drug and alcohol crisis intervention;

(iii) Symptom assessment, management, and individual supportive psychotherapy;

(iv) Medication evaluation and management, administration, monitoring and documentation;

(v) Rehabilitation services;

(vi) Substance abuse treatment services;

(vii) Activities of daily living training and supports;

(viii) Social, interpersonal relationship, and related skills training; and,

(ix) Case management services.

(B) Providers of PACT services are specific teams within an established mental health delivery organization and must be operated by or contracted with and must be certified by the ODMHSAS in accordance with 43A O.S. 319 and Oklahoma Administrative Code 540:55. The unit is a per diem inclusive

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of all services provided by the PACT team. No more than 12 days of service per month may be claimed. Medicaid recipients who are enrolled in this service may not receive other Outpatient Behavioral Health Services except for Crisis Intervention Services (facility based stabilization). The ODMHSAS is responsible for providing the state match for this service.

(b) **Prior authorization of services and requirements.** To be authorized to provide individual, group or family psychotherapy, medication training and support, psychosocial rehabilitation services (individual or group), or Mental Health Services Plan Development (low complexity) the provider must administer fully and document the Client Assessment Record (CAR) evaluation that assesses the client's functional abilities. In some circumstances, a completed CAFAS may be substituted for the CAR assessment when authorized by OHCA or its designated agent. The client must also have a DSM-IV Axis I diagnosis appropriate to his/her symptoms, behaviors, and/or impairments.

(1) The OHCA requires information to be submitted when a provider is requesting prior authorization. If the Medicaid recipient resides in an ICF/MR, or receives Residential Behavioral Management in a Foster Care setting or receives Residential Behavior Management Services in a Group Home setting, the individual service plan required for that service must be included with the request and must reflect the need for the requested Behavioral Health Services. The client must agree to the service plan and sign the request. Requests submitted electronically must have signatures on site and available for auditors with signatures dated prior to, or on, the start date for treatment services. The required information for prior authorization includes:

(A) Pertinent demographic and identifying information;

(B) Complete and current (within 30 days of the date submitted to OHCA or its designated agent) CAR assessment (CAFAS or other recognized functional assessment tools may be substituted in some instances when authorized by OHCA or its designated agent);

(C) Complete multi axial DSM diagnosis using the most current edition with supportive documentation and, if requested by

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OHCA or its designated agent, a mental status examination summary;

(D) Psychiatric and treatment history;

(E) Service plan with goals, objectives and time frames for treatment; and

(F) Services requested.

(2) Medicaid recipients will be considered for prior-authorization after receipt of complete and appropriate information submitted by the provider. Based on diagnosis, functional assessment, history and other Medicaid services being received, the Medicaid recipient may be approved to receive one of four levels of care. There are four levels of care for children and four levels of care for adults. Medicaid recipients who reside in ICF/MRs may be approved for services according to the level of care established for this population.

Medicaid recipients who receive Residential Behavior Management in a Foster Care setting or receive Residential Behavior Management in a Group Home setting may be approved for additional counseling based on demonstrated medical necessity and prior authorization by OHCA or its designated agent, regardless of provider type requesting to perform the additional services. A Medicaid recipient may be approved for a time frame of one to six months. For each level of care the documentation must illustrate the recipient meets the established medical necessity criteria. The OHCA (or its designated agent) will review the request for completeness and appropriateness. A completed request will be reviewed and processed within three business days. Requests will be reviewed by licensed master's prepared therapist (Licensed Clinical Social Workers, Licensed Behavioral Practitioners, Licensed Professional Counselors, Licensed Marriage and Family Therapists) with experience in behavioral health care, or Licensed Registered Nurses with experience in behavioral health care. Psychiatrists, (M.D. and D.O.) and Psychologists possessing current State licenses may be utilized for reviews and appeals.

(3) A prior authorization decision may be appealed by the provider or client if filed within five working days of receipt of the decision. The first level of appeal is to request a reconsideration, which will be performed under the supervision

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of the manager of OHCA's designated agent's Pre-Authorization Unit. If the appeal is not satisfactorily resolved during reconsideration, the provider or client may submit an appeal to the OHCA through its standard grievance process (see OAC 317:2).

(4) Providers seeking prior-authorization will follow OHCA's designated agent's Outpatient Behavioral Health Prior Authorization Manual guidelines for submitting requests on behalf of the Medicaid recipient.

317:30-5-356. Coverage for adults

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

(1) **RHC services.** Payment is limited to four visits per recipient per month. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-51 for exceptions to this limit for children under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Additional preventive service exceptions include:

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

(i) If the clinic compensates the physician, nurse midwife or advanced practice nurse to provide maternity care, then the clinic must bill the Medicaid program for prenatal care as a "maternity encounter". A maternity encounter includes a comprehensive physical examination and/or routine scheduled medical visits. Payment will be allowed for one initial visit and 13 subsequent visits:

(I) three visits during the first trimester;

(II) three visits during the second trimester; and

(III) eight visits during the third trimester.

(ii) If the clinic does not compensate its practitioners to provide maternity care, then the independent practitioner must bill the Medicaid program for obstetrical care according to the method described in the Medicaid provider specific fee-for-service rules for physicians, nurse midwives and advanced practice nurses. (Physician Assistants are excluded from billing the Medicaid program as individual practitioners.)

(iii) Under both billing methods, payment for prenatal

care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(iv) A standard profile of routine obstetrical lab services may be billed separately. The appropriate revenue code and CPT codes are used.

(B) Family planning services. Family planning services are paid on an encounter basis. Coverage of family planning services are available to women between the child bearing age of 12 and 50. Family planning encounters do not count as one of the two RHC visits per month.

(i) A family planning visit includes a physical examination, counseling and prescribing appropriate medications and/or contraceptive methods.

(ii) Prescribed contraceptives may be billed independently from the family planning encounter.

(2) Other ambulatory services. Services defined as "other ambulatory" services are not considered a part of a RHC encounter and are therefore billable to the Medicaid program by the RHC or provider of service on the appropriate claim forms. Other ambulatory services are subject to the same scope of coverage as other Medicaid services billed to the program, i.e., limited adult services and some services for under 21 subject to same prior authorization process. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57 through 317:30-3-60 for general coverage and exclusions under Medicaid fee-for-services. Refer to OAC 317:30-3-51 for exceptions under EPSDT. Some specific limitations are applicable to other ambulatory services as set forth in Specific Provider Rules and excerpted as follows: Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

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317:30-5-1043. Coverage by category

(a) **Adults.** Residential Behavioral Management Services In Group Settings and Non-Secure Diagnostic and Evaluation Center Services are not covered for adults.

(b) **Children.** Residential Behavioral Management Services (RBMS) in Group Settings and Non-Secure Diagnostic and Evaluation Centers are covered for children as set forth in this subsection.

(1) **Description.** Residential Behavior Management Services are provided by Organized Health Care Delivery Systems (OHCDs) for children in the care and custody of the State who have special psychological, behavioral, emotional and social needs that require more intensive care than can be provided in a family or foster home setting. The behavior management services are provided in the least restrictive environment and within a therapeutic milieu. The group setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. Residential Behavior Management Services are reimbursed in accordance with the intensity of supervision and treatment required for the group setting in which the client is placed. Clients residing in a Level E and Intensive Treatment Services (ITS) Group Homes receive maximum supervision and treatment. In addition, ITS group homes provide crisis and stabilization intervention and treatment. Clients residing in a Level D+ Group Home receive highly intensive supervision and treatment. Clients residing in a Level D Group home or in a wilderness camp receive close supervision and moderate treatment. Clients residing in a Level C Group Home receive minimum supervision and treatment. Clients residing in Residential Diagnostic and Evaluation Centers receive intensive supervision and a 20 day comprehensive assessment. Clients residing in a Sanctions Home receive highly intensive supervision and treatment. Clients residing in an Independent Living Group Home receive intensive supervision and treatment. It is expected that RBMS in group settings are an all-inclusive array of treatment services provided in one day. In the case of a child who needs additional specialized services, under the Rehabilitation Option or by a psychologist, prior authorization

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by the OHCA or designated agent is required. Only specialized rehabilitation or psychological treatment services to address unique, unusual or severe symptoms or disorders will be authorized. If additional services are approved, the OHCDs shall collaborate with the provider of such services as directed by the OHCA or its agent. Any additional specialized behavioral health services provided to children in state custody shall be funded in the normal manner. The OHCDs shall provide concurrent documentation that these services are not duplicative. The OHCDs determine the need for RBMS.

(2) **Medical necessity criteria.** The following medical necessity criteria must be met for residential behavior Management Services.

(A) Any DSM-IV AXIS I primary diagnosis, with the exception of V codes, with a detailed description of the symptoms supporting the diagnosis. A detailed description of the child's emotional, behavioral and psychological condition must be on file. A diagnosis is not required for behavior management services provided in Diagnostic and Evaluation centers.

(B) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(C) It has been determined by the OHCDs that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(D) Documentation that the child's presenting emotional and/or behavioral problems prevent the child from living in a traditional family home. The child requires the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff.

(E) The Agency which has permanent or temporary custody of the child agrees to active participation in the child's treatment needs and planning.

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(F) All of the medical necessity criteria must also be met for continued stay in residential group settings.

(3) Treatment components.

(A) **Treatment plan development.** A comprehensive individualized treatment plan for each resident shall be formulated by the Provider Agency staff within 30 days of admission, for ITS level within 72 hours, with documented input from the Agency which has permanent or temporary custody of the child and when possible, the parent. This plan shall be revised and updated at least every three months, every seven days for ITS, with documented involvement of the Agency which has permanent or temporary custody of the child. Documented involvement can be written approval of the treatment plan by the Agency which has permanent or temporary custody of the child. A treatment plan is considered inherent in the provision of therapy and is not covered as a separate item of behavior management services. The treatment plan is individualized taking into account the child's age, history, diagnosis, functional levels, and culture. It includes appropriate goals and time limited and measurable objectives. Each resident's treatment plan shall also address the Provider Agency's plans with regard to the provision of services in each of the following areas:

- (i) Group therapy;
- (ii) Individual therapy;
- (iii) Family therapy;
- (iv) Alcohol and other drug counseling;
- (v) Basic living skills redevelopment;
- (vi) Social skills redevelopment;
- (vii) Behavior redirection; and
- (viii) The Provider Agency's plan to access appropriate

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educational placement services. (Any educational costs are excluded from calculation of the daily rate for behavior management services.)

(B) **Individual therapy.** The Provider Agency shall provide individual therapy on a weekly basis with a minimum of one or more sessions totaling one hour or more of treatment per week to children and youth receiving RBMS in Wilderness Camps, Level D, Level D+ homes, Level E Homes, Independent Living Homes, and Sanctions Homes. ITS Level residents will receive a minimum of five or more sessions totaling a minimum of five or more hours of individual therapy per week. Clients residing in Diagnostic and Evaluation Centers and Level C Group Homes receive Individual Therapy on an as needed basis. Individual therapy must be age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's treatment plan. Individual counseling is a face to face, one to one service, and must be provided in a confidential setting.

(C) **Group therapy.** The Provider Agency shall provide group therapy to children and youth receiving residential behavioral management services. Group therapy must be a face to face interaction, age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's treatment plan. The minimum expected occurrence would be one hour per week in Level D, Level C, Wilderness Camps and Independent Living. Two hours per week are required in Levels D+ and E. Ten hours per week are required in Sanctions Homes, Intensive Treatment Service Level. Group therapy is not required for Diagnostic and Evaluation Centers. Group size should not exceed six members and group therapy sessions must be provided in a confidential setting.

(D) **Family therapy.** Family therapy is a face to face interaction between the therapist/counselor and family, to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding. The Provider Agency shall provide family therapy as indicated by the resident's individual treatment plan. The Agency shall

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work with the caretaker to whom the resident will be discharged, as identified by the OHCDs custody worker. The Agency shall seek to support and enhance the child's relationships with family members (nuclear and appropriate extended), if the custody plan for the child indicates family reunification. The RBMS provider shall also seek to involve the child's parents in treatment team meetings, plans and decisions and to keep them informed of the child's progress in the program. Any service provided to the family must have the child as the focus.

(E) **Alcohol and other drug abuse treatment education, prevention, therapy.** The Provider Agency shall provide alcohol and other drug abuse treatment for residents who have emotional or behavioral problems related to substance abuse/chemical dependency, to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. This service shall be considered ancillary to any other formal treatment program in which the child participates for treatment and rehabilitation. For residents who have no identifiable alcohol or other drug use, abuse, or dependency age appropriate education and prevention activities are appropriate. These may include self esteem enhancement, violence alternatives, communication skills or other skill development curriculums.

(F) **Basic living skills redevelopment.** The Provider Agency shall provide goal directed activities designed for each resident to restore, retain, and improve those basic skills necessary to independently function in a family or community. Basic living skills redevelopment is age appropriate and relevant to the goals and objectives of the treatment plan. This may include, but is not limited to food planning and preparation, maintenance of personal hygiene and living environment, household management, personal and household shopping, community awareness and familiarization with community resources, mobility skills, job application and retention skills.

(G) **Social skills redevelopment.** The Provider Agency shall

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provide goal directed activities designed for each resident to restore, retain and improve the self help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These are age appropriate, culturally sensitive and relevant to the goals of the individual treatment plan. For ITS level of care, the minimum skill redevelopment per day is three hours. Any combination of basic living skills and social skills redevelopment that is appropriate to the need and developmental abilities of the child is acceptable.

(H) **Behavior redirection.** The Provider Agency shall be able to provide behavior redirection management by agency staff as needed 24 hours a day, 7 days per week. The Agency shall ensure staff availability to respond in a crisis to stabilize residents' behavior and prevent placement disruption. In addition, ITS group homes will be required to provide crisis stabilization interaction and treatment for new residents 24 hours a day, seven days a week.

(4) **Providers.** For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services of their providers, the providers of individual, group and family therapies must:

(A) be a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, or under Board Supervision to be licensed in one of the above stated areas; or

(B) have one year of experience in a behavioral health treatment program and a master's degree in a mental health treatment field licensable in Oklahoma by one of the following licensing boards:

- (i) Psychology,
- (ii) Social work (clinical specialty only),
- (iii) Licensed professional counselor,

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(iv) Licensed marriage and family therapist, or

(v) Licensed behavioral practitioner; or

(C) have a baccalaureate degree in a mental health field in one of the stated areas listed in (B) of this paragraph AND three or more years post-baccalaureate experience in providing direct patient care in a behavioral health treatment setting and be provided a minimum of weekly supervision by a staff member licensed as listed in (A) of this paragraph; or

(D) be a registered psychiatric nurse; AND

(E) demonstrate a general professional or educational background in the following areas:

(i) case management, assessment and treatment planning;

(ii) treatment of victims of physical, emotional, and sexual abuse;

(iii) treatment of children with attachment disorders;

(iv) treatment of children with hyperactivity or attention deficit disorders;

(v) treatment methodologies for emotional disturbed children and youth;

(vi) normal childhood development and the effect of abuse and/or neglect on childhood development;

(vii) treatment of children and families with substance abuse and chemical dependency disorders;

(viii) anger management; and

(ix) crisis intervention.

(5) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services provided by their staff for behavior

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management therapies (Individual, Group, Family) as of January 1, 2004, providers must have the following qualifications:

(A) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, or under Board approved Supervision to be licensed in one of the above stated areas; or

(B) be licensed as an Advanced Practice Nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided,
AND

(C) demonstrate a general professional or educational background in the following areas:

(i) case management, assessment and treatment planning;

(ii) treatment of victims of physical, emotional, and sexual abuse;

(iii) treatment of children with attachment disorders;

(iv) treatment of children with hyperactivity or attention deficit disorders;

(v) treatment methodologies for emotionally disturbed children and youth;

(vi) normal childhood development and the effect of abuse and/or neglect on childhood development;

(vii) treatment of children and families with substance abuse and chemical dependency disorders;

(viii) anger management; and

(ix) crisis intervention.

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(D) Staff providing basic living skills redevelopment, social skills redevelopment, and alcohol and other substance abuse treatment, shall meet one of the following areas:

(i) Bachelor's or Master's degree in a behavioral health related field including but not limited to, psychology, sociology, criminal justice, school guidance and counseling, social work, occupational therapy, family studies; or

(ii) a current license as a registered nurse in Oklahoma; or

(iii) certification as an Alcohol and Drug Counselor is allowed to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSMIV Axis I diagnosis; or

(iv) current certification as a Behavioral Health Case Manager from DMHSAS and meets OHCA requirements to perform case management services, as described in OAC 317:30-5-595(7).

(E) Staff providing behavior redirection services must have current certification and required updates in nationally recognized behavior management techniques, such as CAPE or MANDT. Additionally, staff providing these services must receive initial and ongoing training in at least one of the following areas: anger management, crisis intervention, normal child and adolescent development and the effect of abuse, neglect and/or violence on such development, grief and loss issues for children in out of home placement, interventions with victims of physical, emotional and sexual abuse, care and treatment of children with attachment disorders, care and treatment of children with hyperactive, or attention deficit, or conduct disorders, care and treatment of children, youth and families with substance abuse and chemical dependency disorders, passive physical restraint procedures, procedures for working with delinquents or the Inpatient Mental Health and Substance Abuse Treatment of Minor's Act.

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(F) In addition, Behavioral Management staff shall have access to consultation with an appropriately licensed mental health professional.

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OAC 317:30-5-1046

317:30-5-1046. Documentation of records and records review

(a) The OHCDs and the facilities with whom it contracts must maintain appropriate records system. Current treatment plans, case files, and progress notes are maintained in the facilities' files during the time the child or youth is receiving services. All services rendered must be reflected by documentation in the case records.

(b) OHCA and the Centers for Medicare and Medicaid Services (CMS) may evaluate through inspection or other means, the quality, appropriateness and timeliness of services provided by the OHCDs or facilities with whom it contracts.

(c) All residential behavioral management services in group settings and non-secure diagnostic and evaluation centers must be reflected by documentation in the patient records. Individual, group, family, and alcohol and other drug counseling, and social and basic living skills development services must include all of the following:

- (1) date;
- (2) start and stop time for each session;
- (3) signature of the therapist/staff providing service;
- (4) credentials of therapist/staff providing service;
- (5) specific problem(s) addressed (problem must be identified on master treatment plan);
- (6) methods used to address problem(s);
- (7) progress made toward goals;
- (8) patient response to the session or intervention; and
- (9) any new problem(s) identified during the session.

317:40-1-1. Home and Community-Based Waiver Services for persons with certain developmental disabilities

(a) **Applicability.** The rules in this Section apply to services funded through Medicaid Home and Community-Based Waivers (HCBW) as defined in Section 1915(c) of the Social Security Act and administered by the Oklahoma Department of Human Services DHS, Developmental Disabilities Services Division (DDSD). The specific waivers are the In-Home Supports Waivers (IHSW), the Community Waiver, and the Homeward Bound Waiver.

(b) **Program Administration.** Services funded through a Home and Community-Based Waiver for persons with mental retardation or related conditions are administered by DDSD, under the oversight of the Oklahoma Health Care Authority (OHCA), the State Medicaid agency. The rules in this subsection shall not be construed as a limitation of the rights of class members set forth in the Consent Decree in Homeward Bound vs. The Hisson Memorial Center.

(1) HCBW services are subject to annual appropriations by the Oklahoma Legislature.

(2) DDSD must limit the utilization of the HCBW services based on:

(A) the federally-approved capacity of the HCBW services for the individual Waivers;

(B) cost-effectiveness of the HCBW services for the individual Waivers; and

(C) State appropriations.

(3) DDSD must limit enrollment when utilization of the HCBW services program is projected to exceed the spending authority.

(c) **Program provisions.** Each individual requesting HCBW services and his or her family or guardian are responsible for:

(1) accessing, with the assistance of DHS staff, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under the Home and Community-Based Waiver program;

(2) cooperating in the determination of medical and financial eligibility, including prompt reporting of changes in income or resources; and

(3) choosing between Home and Community-Based Waiver services and institutional care.

(d) **Waiver Eligibility.**

(1) HCBW services are available to Oklahoma residents meeting Medicaid eligibility requirements established by law, regulatory authority, and policy within funding available through State or Federal resources. To be eligible for and receive services funded through any of the Waivers listed in subsection (a) of this Section, a person must first be determined financially eligible for Medicaid through the DHS Family Support Services Division. The Medicaid eligible individual may not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, nursing facility, residential care facility as described in Section 1-819 of Title 63 of Oklahoma Statutes, or ICF/MR facility. The individual may also not be receiving DDS state-funded services such as the Family Support Assistance Payment, sheltered workshop services, community integrated employment services, or assisted living without waiver supports as described in OAC 340:100-5-22.2. The individual must also meet other Waiver-specific eligibility criteria.

(A) In-Home Supports Waivers. To be eligible for services funded through the In-Home Supports Waivers (IHSW), a person must:

(i) meet all criteria for HCBW services given in subsection (d) of this Section;

(ii) be determined to have a disability, with a diagnosis of mental retardation, by:

(I) the Social Security Administration; or

(II) the Oklahoma Health Care Authority, Level of Care Evaluation Unit;

(iii) be three years of age or older;

(iv) be determined by the Oklahoma Health Care Authority, Level of Care Evaluation Unit, to meet the ICF/MR Institutional Level of Care requirements in accordance with OAC 317:30-5-122;

(v) reside in:

(I) the home of a family member or friend;

(II) his or her own home;

(III) a DHS Children and Family Services Division (CFSD) foster home; or

(IV) a CFSD group home; and

(vi) have critical support needs that can be met through a combination of non-paid, non-Waiver, and State Plan resources available to the individual, and within the annual per capita Waiver limit agreed between the State of Oklahoma and the Centers for Medicare and Medicaid Services (CMS).

(B) Community Waiver. To be eligible for services funded through the Community Waiver, the person must:

(i) meet all criteria given in subsection (d) of this Section;

(ii) be age three or older;

(iii) have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDSD Division Director or designee;

(iv) be determined, in accordance with either subunit I or both subunits II and III of this unit:

(I) to have mental retardation or a related condition by the Mental Retardation Authority and to have resided in a nursing facility, in accordance with the provisions of 42 CFR 483.100 *et seq*; or

(II) to have a disability, with a diagnosis of mental retardation, by the Social Security Administration or the Oklahoma Health Care Authority, Level of Care Evaluation Unit; and

(III) to meet the ICF/MR Institutional Level of Care

requirements by the Oklahoma Health Care Authority, Level of Care Evaluation Unit.

(C) To be eligible for services funded through the Homeward Bound Waiver, the person must:

(i) be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hisson Memorial Center*, Case No. 85-C-437-E;

(ii) meet all criteria for HCBW services given in subsection (d) of this Section; and

(iii) be determined to:

(I) have mental retardation or a related condition by the Mental Retardation Authority and to have resided in a nursing facility, in accordance with the provisions of 42 CFR 483.100 et seq; or

(II) meet the ICF/MR Institutional Level of Care requirements by the Oklahoma Health Care Authority, Level of Care Evaluation Unit.

(2) The person desiring services through any of the Waivers listed in subsection (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBW services eligibility, including:

(A) a psychological evaluation, current within one year, which includes:

(i) a functional assessment; and
(ii) a statement of age of onset of the disability;

(B) a social service summary, current within one year, which includes a developmental history; and

(C) a medical evaluation current within 90 days.

(3) The Oklahoma Health Care Authority reviews the diagnostic reports listed in paragraph (2) of this subsection and makes a determination of eligibility for DDS services and ICF/MR level of care for the services funded through the IHSW or the Community Waiver.

(4) For individuals who are determined to have mental retardation or a related condition by the Mental Retardation Authority in accordance with the provisions of 42 CFR 483.100 *et seq*, DDS/D reviews the diagnostic reports listed in paragraph (2) of this subsection and, on behalf of the OHCA, makes a determination of eligibility for DDS/D services and ICF/MR level of care.

(5) A determination of need for ICF/MR Institutional Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

(e) **Waiting list.** When State DDS/D resources are unavailable for new persons to be added to services funded through a Home and Community-Based Waiver, persons are placed on a statewide waiting list for services.

(1) The waiting list is maintained in chronological order based on the date of receipt of a written request for services.

(2) The waiting list for persons requesting HCBW services is administered by DDS/D uniformly throughout the state.

(3) An individual is removed from the waiting list if the individual:

(A) is found to be ineligible for services;

(B) cannot be located by DHS;

(C) does not provide required information to DHS;

(D) is not a resident of the state of Oklahoma; or

(E) is offered Waiver services through either the In-Home Supports Waiver or the Community Waiver and declines services.

(f) **Applications.** When resources are sufficient for initiation of HCBW services, DDS/D action regarding a request for services occurs within 45 days. If action is not taken within the required 45 days, the applicant may seek resolution as described in OAC 340:2-5.

(1) Applicants are allowed 60 days to provide information requested by DDS to determine eligibility for services.

(2) If requested information is not provided within 60 days, the applicant is notified that the request has been denied, and the individual is removed from the waiting list.

(g) **Admission protocol.** Initiation of services funded through a Home and Community-Based Waiver occurs in chronological order from the waiting list in accordance with subsection (e) of this Section based on the date of DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or his or her legal guardian, and upon determination of eligibility, in accordance with subsection (d) of this Section. Exceptions to the chronological requirement may be made when:

(1) an emergency situation exists in which the health or safety of the person needing services, or of others, is endangered, and there is no other resolution to the emergency. An emergency exists when:

(A) the person is unable to care for himself or herself and:

(i) the person's caretaker, as defined in Section 10-103 of Title 43A of the Oklahoma Statutes:

(I) is hospitalized;

(II) has moved into a nursing facility;

(III) is permanently incapacitated; or

(IV) has died; and

(ii) there is no caretaker to provide needed care to the individual; or

(iii) an eligible person is living at a homeless shelter or on the street;

(B) the Department of Human Services finds that the person needs protective services due to experiencing ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to

the person's health or safety;

(C) the behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or

(D) the person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so.

(2) the Legislature has appropriated special funds with which to serve a specific group or a specific class of individuals;

(3) Waiver services are required for people who transition to the community from a public intermediate care facility for persons with mental retardation (ICF/MR) or who are children in the State's custody receiving services from DHS; or

(4) individuals residing in nursing facilities prior to January 1, 1989, who are determined by PASRR evaluation conducted pursuant to the provisions of 42 CFR 483.100 *et seq* to have mental retardation or a related condition, choose to receive services funded through the Community Waiver.

(h) **Movement within DDS HCBW services.** A person's movement from services funded through one Home and Community-Based Waiver to services funded through another DDS-administered Waiver is explained in this subsection.

(1) When a child receiving services funded through the IHSW becomes 18 years of age, IHSW services for adults become effective.

(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:

(A) a person has critical support needs which cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDS Director or designee; and

(B) funding is available in accordance with subsection (b) of

this Section.

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when an individual's history of annual service utilization has been within the per capita allowance of the IHSW.

(4) When an individual served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the IHSW and through a combination of non-Waiver resources, the individual may choose to receive services through the IHSW.

(i) Continued eligibility for HCBW services. Eligibility for children receiving HCBW services is re-determined when:

(1) a child who is receiving HCBW services prior to age six reaches age six. The child must be determined to continue to have a disability with a diagnosis of mental retardation. The determination must be made no later than the first Plan of Care review after the seventh birthday. A new diagnostic evaluation is required in accordance with paragraph (d)(2) of this subsection;

(2) a child who is receiving HCBW services reaches age 18. The service recipient must be determined to continue to have a disability with a diagnosis of mental retardation if a determination has not been made by Social Security. The determination must be made at the first Plan of Care review after the nineteenth birthday. A new diagnostic evaluation is required in accordance with paragraph (d)(2) of this subsection; and

(3) required by DDS. DDS may require a new diagnostic evaluation in accordance with paragraph (d)(2) of this subsection and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status determined under paragraph (d)(2) of this Section has been noted.

(j) HCBW services case closure. HCBW services are terminated when an individual receiving services:

(1) or the service recipient's legal guardian chooses to no longer receive Waiver services;

- (2) is incarcerated;
- (3) is financially ineligible to receive Waiver services;
- (4) is determined by the Social Security Administration to no longer have a disability;
- (5) is determined by the Oklahoma Health Care Authority Level of Care Evaluation Unit to no longer be eligible;
- (6) moves out of state, or the custodial parent or guardian of a minor moves out of state;
- (7) is admitted to a nursing facility, ICF/MR, residential care facility, or mental health facility for more than 30 consecutive days;
- (8) or the guardian of a minor or adjudicated adult fails to cooperate during the annual review process as described in OAC 340:100-5-50 through 100-5-58;
- (9) or the guardian of a minor or adjudicated adult fails to cooperate in the implementation of DHS policy or service delivery in a manner that places the health or welfare of the service recipient at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services have not been effective; or
- (10) is determined to no longer be Medicaid eligible.

(k) Reinstatement of services. Waiver services are reinstated when:

- (1) the situation resulting in case closure of a Hisson class member is resolved;
- (2) a service recipient is incarcerated for 90 days or less;
- (3) a service recipient is admitted to a nursing facility, ICF/MR, residential care facility, or mental health facility for 90 days or less; or
- (4) a service recipient's Medicaid eligibility is re-established within 90 days of the date of the DDSD Notice of Action.

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- 317:40-5-2. Purpose **[REVOKED]**
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- 317:40-5-4. Provider selection
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- 317:40-5-6. Provider approval
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PART 7. STANDARDS AND GUIDELINES FOR SPECIALIZED FOSTER CARE

- 317:40-5-75. Standards for Specialized Foster Care and respite homes
- 317:40-5-76. Guidelines for home profile

PART 9. SERVICE PROVISIONS

- 317:40-5-100. Assistive technology services
- 317:40-5-101. Architectural modifications
- 317:40-5-102. Nutritional Services
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- 317:40-5-110. Authorization for Habilitation Training Specialist Services
- 317:40-5-111. Authorization for Habilitation Training Specialist Services in the Homeward Bound Waiver
- 317:40-5-112. Dental Services for Homeward Bound Class Members

PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

- 317:40-5-150. Daily Living Supports
- 317:40-5-151. Intensive Personal Supports
- 317:40-5-152. Group home services for persons with mental retardation

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- 317:40-5-153. Daily Living Supports for the Homeward Bound Waiver
- 317:40-5-154. Intensive Personal Supports in the Homeward Bound Waiver

317:40-5-111. Authorization for Habilitation Training Specialist Services in the Homeward Bound Waiver

(a) Habilitation Training Specialist (HTS) Services are authorized as a result of needs identified by the Personal Support Team and informed service recipient selection.

(b) HTS Services may be provided in the Homeward Bound waiver in service settings including:

(1) agency companion services as described in OAC 317:40-5-1 through OAC 317:40-5-39;

(2) daily living supports as described in OAC 317:40-5-153;

(3) specialized foster care as described in OAC 317:40-5-50 through OAC 317:40-5-76;

(4) group home services as described in OAC 340:100-6; and

(5) the class member's own home, family's home, or other community residential setting.

(c) HTS services are authorized only during periods when staff are engaged in purposeful activity that directly or indirectly benefits the person receiving services.

(1) Staff must be physically able and mentally alert to carry out the duties of the job.

(2) At no time are HTS services authorized for periods during which the staff are allowed to sleep.

317:40-5-112. Dental Services for Homeward Bound Class Members

(a) **Service Description.** Dental services include oral examinations, appropriate radiographs, prophylaxis, development of a written treatment plan, and routine training of the service recipient or primary care giver regarding oral hygiene, and other services recommended by a dentist. Preventative, restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review, if required as identified in subsection (e).

(b) **Applicability.** This section applies only to members of the Homeward Bound vs. The Hisson Memorial Center class certified in Case Number 85-C-437-E, United States District Court for the Northern District of Oklahoma.

(c) **Standard of Care.** Developmental Disabilities Services Division (DDSD) arranges for provision of comprehensive diagnostic and treatment services for each person eligible to receive such services from qualified personnel, including licensed dentists and dental hygienists. OAC 317:30, Part 79, and any dental guidelines published by the Oklahoma Health Care Authority must be followed.

(d) **Providers.** Providers of dental services must hold a non-restrictive license to practice dentistry in the State of Oklahoma or the State where treatment is rendered.

(e) **Treatment Plans.** A dental treatment plan for proposed treatment must be submitted to the service recipient and Personal Support Team (Team) for review. The DDSD Area Medical Director or designee must approve treatment plans exceeding \$650.00.

(f) **Frequency of Examination.** The provider dentist and the Team determine frequency of examination on an individual basis.

(g) **Documentation of Dental Services.** The dental provider summarizes a record of dental services provided on OKDHS Form DDS-5, Referral Form for Examination or Treatment, or comparable form.

(h) **Prevention.** The Individual Plan must identify outcomes for the prevention of dental disease and the promotion of dental health. Independence in oral hygiene care is promoted. If the service recipient is unable to maintain adequate oral hygiene as determined by the provider dentist and the Team, effective direct assistance

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and responsibility must be assigned to appropriate Team members in the Individual Plan.

317:40-5-153. Daily Living Supports for the Homeward Bound Waiver

(a) Introduction. Daily Living Supports are provided by an agency with a valid OHCA contract, approved by DDS, for the service.

(1) Daily Living Supports require meeting the daily support needs of the people living in the home.

(A) In accordance with the needs of the class member, Daily Living Supports include hands-on assistance, supervision, or prompting so that the person performs the task, such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, money management, community safety, recreation, social, health, or medication management.

(B) Daily Living Supports also include assistance with cognitive tasks or provision of services to prevent an individual from harming self or others, in accordance with the needs of the person receiving services.

(C) Daily Living Supports also include:

(i) the provision of staff training to meet the specific needs of the service recipient;

(ii) program supervision; and

(iii) program oversight.

(2) Daily Living Supports are used to provide and fund up to eight hours per day of supports for class members receiving supported living services as detailed in OAC 340:100-5-22.5.

(b) Eligibility. Daily Living Supports, as described in this Section, are provided to individuals who:

(1) are members of the class certified in Case Number 85-C-437-E, U.S. District Court for the Northern District of Oklahoma;

(2) receive community residential services in their own home; and

(3) do not simultaneously receive any other community residential or group home services.

(c) Responsibilities of provider agencies. Each provider agency providing Daily Living Supports must:

(1) ensure ongoing supports as needed to all service recipients living in the home when one or more service recipients is out of the home visiting family and friends, or hospitalized for psychiatric or medical care;

(2) ensure compliance with all applicable DDSD policy found at OAC 340:100; and

(3) provide for the welfare of all service recipients living in the home.

(d) Criteria for direct support staff services in the Homeward Bound Waiver beyond eight hours per day. Additional direct support services including HTS, Homemaker, or Intensive Personal Supports, beyond the average of eight hours per day referenced in subsection (a) of this Section, are provided based on needs identified by the Personal Support Team.

(e) Daily Living Supports claims. No more than 365 units of Daily Living Supports may be billed per year, except Leap Year, for each individual receiving services.

(1) The provider agency claims one unit of service for each day the individual receives Daily Living Supports.

(2) Providers must claim at least monthly for all days that Daily Living Supports were actually provided during the preceding month. Claims must not be based on budgeted amounts.

(3) When an individual changes provider agencies, only the outgoing service provider agency claims for the day that the individual moves.

(f) Billing for other support services. The provider agency may claim separately for additional support services such as HTS, Intensive Personal Supports, or Homemaker Services provided to an individual receiving Daily Living Supports, if:

(1) additional support services have been authorized in the person's Plan of Care; and

(2) eight hours of direct staff support, excluding Nursing, have already been provided to the person that day. If support services are provided to multiple individuals residing in the same household at the same time, the provider agency cannot count these hours toward each individual's eight-hour minimum. For example, three hours of HTS provided simultaneously by a single direct contact staff to three residents in the same household may only be counted as three hours of HTS for one of the individuals, not three hours for each resident.

(g) **Therapeutic leave.** Therapeutic leave is a Medicaid payment made to the Daily Living Supports contract provider to enable the service recipient to retain direct support services.

(1) Therapeutic leave is claimed when the service recipient does not receive Daily Living Supports services for 24 consecutive hours because of:

(A) a visit with family or friends without direct support staff;

(B) vacation without direct support staff; or

(C) hospitalization, whether direct support staff are present or not. Daily living supports staff are present with the individual in the hospital as approved by the person's Team in the Individual Plan.

(2) An individual may receive therapeutic leave for no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year.

(3) The payment for a day of therapeutic leave is the same amount as the per diem rate for Daily Living Supports.

(4) If, because of the service recipient's absence, the direct support staff member is unable to work, the provider pays the staff member the salary that he or she would have earned if the service recipient were not on therapeutic leave.

317:40-5-154. Intensive Personal Supports in the Homeward Bound Waiver

(a) **Introduction.** Intensive Personal Supports are support services provided to class members who need an enhanced level of direct support in order to successfully reside in a community based setting. Intensive Personal Supports build upon the level of support provided by a Habilitation Training Specialist or Daily Living Supports staff by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, recreational, and habilitation activities.

(b) **Eligibility.** Intensive Personal Supports are provided by OHCA contracted provider agencies to class members who:

(1) are eighteen years of age or older, unless approved by the Director of OKDHS or designee; and

(2) require a second support staff in order to meet their needs, when there is no other resolution.

(c) **Service requirements.** Intensive Personal Supports are limited to 24 hours per day and must be:

(1) included in the class member's Individual Plan in accordance with OAC 340:100-5-53;

(2) authorized in the Plan of Care; and

(3) provided in conjunction with Habilitation Training Services.

(d) **Responsibilities of provider agencies.** Each provider agency providing Intensive Personal Supports must:

(1) have current, valid contracts with OHCA and OKDHS/DDSD; and

(2) ensure that any staff member providing Intensive Personal Supports has completed the training in accordance with OAC 340:100-3-38.