
POLICY TRANSMITTAL NO. 05-19	DATE: MAY 24, 2005
AGING SERVICES DIVISION/OKLAHOMA HEALTH CARE AUTHORITY	DEPARTMENT OF HUMAN SERVICES OFFICE OF PLANNING, POLICY & RESEARCH

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-5-30; 30-5-31; 30-5-34; 30-5-123; 30-5-131.2; 30-5-700;
and 35-19-14.

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

Physician Assistant rules are revised to allow reimbursement at the same allowable as Physicians and Advance Practice Nurses. Revisions allow reimbursement to Physician Assistants at 100% of the Physicians fee schedule, consistent with reimbursement to Physicians and Advance Practice Nurses.

Long Term Care Facilities rules are revised to:

- (1) provide reference to the Oklahoma State Department of Health recently revised rules which allow the implementation of flexible staff scheduling. Other revisions provide instructions to facilities regarding the completion of the newly revised Quality of Care Report;
- (2) outline the states' responsibility for screening all individuals for mental illness or mental retardation or related conditions who apply to or reside in nursing facilities; and
- (3) comply with Federal Pre-Admission Screening and Resident Review requirements, which outline the states' responsibility for screening all individuals for mental illness or mental retardation or related conditions who apply to or reside in Title XIX certified nursing facilities.

Medical Providers-Fee for Service, Dentists specific, rules are revised to improve access for Medicaid eligible children to orthodontic services by allowing general or pediatric dentists, under certain conditions, to be reimbursed for orthodontic services.

Original signed on 5-13-05

Roy Keen, Director
Aging Services Division

Sharon Neuwald, Co-Interim Administrator
Office of Planning, Policy & Research

WF # 04-I (DT)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

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

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

REMOVE

INSERT

317:30-5-30	317:30-5-30, 1 page only, revised 7-1-04
317:30-5-31	317:30-5-31, 1 page only, revised 7-1-04
317:30-5-34	-----
317:30-5-123	317:30-5-123, pages 1-8, revised 7-1-04
317:30-5-131.2	317:30-5-131.2, pages 1-9, revised 4-1-04
317:30-5-700	317:30-5-700, 1 page only, revised 7-6-04
317:35-19-14	317:35-19-14, 1 page only, revised 7-1-04

317:30-5-30. Eligible providers

The Oklahoma Health Care Authority (OHCA) recognizes medical services rendered by a Physician Assistant in accordance with the rules and regulations covering the Authority's medical care program.

(1) The application for a Medicaid Provider agreement must be accompanied by copies of the physician assistant's current written authorization to practice from the Oklahoma State Board of Medical Licensure and Supervision. The Application to Practice must be jointly filed by the supervising physician and physician assistant and include a description of the physician's practice, methods of supervision and utilization of the physician assistant, and the name of alternate supervising physician(s) who will supervise the physician assistant in the absence of the primary supervising physician. At any time that the supervising physician(s) change, an updated copy of the certification must be submitted to OHCA, Provider Enrollment.

(2) All services provided by a Physician Assistant must be within the current practice guidelines for the State of Oklahoma.

**MEDICAL PROVIDERS-FEE FOR SERVICE
PHYSICIAN ASSISTANTS SPECIFIC**

OAC 317:30-5-31

317:30-5-31. General coverage by category

Physician Assistant services are subject to all rules and guidelines which apply to Physician services as specified at OAC 317:30-5, Part 1, Physicians.

317:30-5-123. Patient certification for long term care

(a) **Medical eligibility.** Initial approval of medical eligibility for long-term care is determined by the OKDHS area nurse, or nurse designee. The certification is obtained by the facility at the time of admission.

(1) **Pre-admission screening.** Federal Regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) for individuals with mental illness and mental retardation. PASRR applies to the screening or reviewing of all individuals for mental illness or mental retardation or related conditions who apply to or reside in Title XIX certified nursing facilities regardless of the source of payment for the nursing facility services and regardless of the individual's or resident's known diagnoses. The NF must independently evaluate the Level I PASRR Screen regardless of who completes the form and determine whether or not to admit an individual to the facility. NFs which inappropriately admit a person without a PASRR Screen are subject to recoupment of funds. There are no PASRR requirements for individuals seeking residency in an intermediate care facility for the mentally retarded (ICF/MR) or in Medicare Skilled beds.

(2) **PASRR Level I screen.**

(A) Form LTC-300A, Long Term Care Pre-admission Screen, must be completed by an authorized official of OKDHS, of the nursing facility, of the hospital or a physician. An authorized official is defined as:

- (i) A licensed nurse from OKDHS;
- (ii) The nursing facility administrator or co-administrator;
- (iii) A licensed nurse from the nursing facility, hospital, or physician's office;
- (iv) A social service director from the nursing facility or hospital; or
- (v) A social worker from the nursing facility, or the hospital.

(B) The authorized official as defined in (1) of this subsection must evaluate the properly completed OHCA Form LTC-300A and/or the Uniform Comprehensive Assessment Tool and/or the Minimum Data Set (MDS). Any other readily available medical and social information is also used to determine if there currently exists any indication of mental illness (MI), mental retardation (MR), or other related condition, or if such condition existed in the applicant's past history. This evaluation constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II Assessment is necessary prior to allowing the patient to be admitted.

(C) The nursing facility is responsible for determining from the evaluation whether or not the patient can be admitted to the facility. A "yes" response to any question from Form LTC-300A, Section I, will result in a consultation with the Level of Care Evaluation Unit (LOCEU) to determine if a Level II Assessment is needed. If there is any question as to whether or not there is evidence of MI, MR, or related condition, LOCEU should be contacted prior to admission.

(D) Upon receipt and review of the medical eligibility information packet, the LOCEU may, in coordination with the OKDHS area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II Assessment is not required, the process of determining medical eligibility continues. If a Level II is required, a medical decision is not made until the results of the Level II Assessment are known.

(3) Level II Assessment for PASRR.

(A) Any one of the following three circumstances will allow a patient to enter the nursing facility without being subjected to a Level II PASRR Assessment.

(i) The patient has no current indication of mental illness or mental retardation or other related condition and there is no history of such condition in the patient's past.

(ii) The patient does not have a diagnosis of mental

**MEDICAL PROVIDERS-FEE FOR SERVICE
LONG TERM CARE
FACILITIES SPECIFIC**

OAC 317:30-5-123 p(3)

retardation or related condition, and a primary or secondary diagnosis of dementia including dementia of the Alzheimer's type is documented in writing by a physician.

(iii) The patient has indications of mental illness or mental retardation or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery. If an individual is admitted to an NF based on **Exempted Hospital Discharge**, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital Discharge is allowed if the following three conditions are met:

(I) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);

(II) The individual must require NF services for the condition for which he/she received care in the hospital; and

(III) The attending physician must certify in writing before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(B) If the patient has current indications of mental illness or mental retardation or other related condition, or if there is a history of such condition in the patient's past, the patient cannot be admitted to the nursing facility. Instead, a Level II PASRR Assessment must be performed and the results must indicate that nursing facility care is appropriate prior to allowing the patient to be admitted.

(C) The State Mental Retardation (MR) (OKDHS/Developmental Disabilities Services Division) and Mental Illness (MI) (Department of Mental Health and Substance Abuse Services) authorities have developed **Advance Group Determinations** by category that take into account certain diagnoses, levels of severity of illness, or need for a particular service which clearly indicate that admission to an NF is normally needed, and that the provision of specialized services is not

**MEDICAL PROVIDERS-FEE FOR SERVICE
LONG TERM CARE
FACILITIES SPECIFIC**

OAC 317:30-5-123 p(4)

normally needed. These determinations are actual Level II decisions and not exemptions from the screening process. For those for whom a categorical determination is made, both the level of care determination and the specialized services determination must be addressed. All positive determinations concerning the need for specialized services must be based on a more extensive individualized evaluation.

(D) The OHCA, LOCEU, authorizes Advance Group Determinations for the MI and MR Authorities in the following categories:

(i) **Provisional admission in cases of delirium.** Any person with mental illness, mental retardation or related condition that is not a danger to self and or others, may be admitted to a Title XIX certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

(I) A Level II evaluation is completed immediately after the delirium clears. The LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(II) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(ii) **Provisional admission in emergency situations.** Any person with a mental illness, mental retardation or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facility for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. The LOCEU must be provided with written documentation from OKDHS Adult Protective Services, or the NF, which supports the individual's

**MEDICAL PROVIDERS-FEE FOR SERVICE
LONG TERM CARE
FACILITIES SPECIFIC**

OAC 317:30-5-123 p(5)

emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

(iii) **Respite care admission.** Any person with mental illness, mental retardation or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to 15 consecutive days per stay, not to exceed 30 days per calendar year.

(I) In rare instances, such as illness of the caregiver, an exception may be granted to allow 30 consecutive days of respite care. However, in no instance can respite care exceed 30 days per calendar year.

(II) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(4) Resident Review.

(A) The nursing facility's routine resident assessment will identify those individuals previously undiagnosed as MR or MI. A new condition of MR or MI must be referred to LOCEU by the NF for determination of the need for the Level II Assessment. The facility's failure to refer such individuals for a Level II Assessment will result in recoupment of funds.

(B) A Level II Resident Review must be conducted the following year for each resident of a nursing facility who was found to experience a serious mental illness on their pre-admission Level II, to determine whether, because of the resident's physical and mental condition, the resident requires the level of services provided by a nursing facility and whether the resident requires specialized services.

(C) A significant change in a resident's physical or mental condition could trigger a Level II Resident Review. If such a change should occur in a resident's condition, it is the responsibility of the nursing facility to notify the LOCEU of the need to conduct a resident review.

(5) **Results of Level II Pre-Admission Assessment and Resident Review.** Through contractual arrangements between the OHCA and the MI/MR authorities, individualized assessments are conducted and findings presented in written evaluations. The evaluations determine if nursing facility services are needed, if specialized services or lesser than specialized services are needed and what types, and if the individual meets the federal PASRR definition of mental illness or mental retardation or related conditions. Evaluations are delivered to the LOCEU to process formal, written notification to patient, guardian, NF and interested parties.

(6) **Readmissions, and interfacility transfers.** The Preadmission Screening process does not apply to readmission of an individual to an NF after transfer for a continuous hospital stay, and then back to the NF. There is no specific time limit on the length of absence from the nursing facility for the hospitalization. Inter-facility transfers are subject to Resident Reviews rather than preadmission screening. In the case of transfer of a resident from an NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent LTC-300A and any PASRR evaluations accompany the transferring resident. The receiving NF must submit an updated LTC-300A that reflects the resident's current status to LOCEU within 30 days of the transfer. Failure to do so could result in possible recoupment of funds.

(7) **PASRR appeals process.**

(A) Any individual who has been adversely affected by any PASRR determination made by the State in the context of either a preadmission screening or an annual resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county OKDHS office to discuss a

**MEDICAL PROVIDERS-FEE FOR SERVICE
LONG TERM CARE
FACILITIES SPECIFIC**

OAC 317:30-5-123 p(7)

hearing. Any request for a hearing must be made no later than 30 days following the date of written notice. All individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(B) When the individual is found to experience MI, MR, or related condition through the Level II Assessment, the PASRR determination made by the MR/MI authorities cannot be countermanded by the state Title XIX agency, either in the claims process or through other utilization control/review processes, or by the state survey and certification agency. Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the MR/MI authorities.

(b) Determination of Title XIX medical eligibility for long term care. The determination of medical eligibility for care in a nursing facility is made by the OKDHS area nurse, or nurse designee. The procedures for determining Nursing Facility (NF) program medical eligibility are found in OAC 317:35-19. Determination of ICF/MR medical eligibility is made by LOCEU. The procedures for obtaining and submitting information required for a decision are outlined below.

(1) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ICF/MR care is based on results of a current comprehensive psychological evaluation by a licensed psychologist or state staff psychologist, documentation of MR or related condition prior to age 22, and the need for active treatment according to federal standards. Pre-approval is made by LOCEU analysts.

(2) **Medical eligibility for ICF/MR services.** Within 30 calendar days after services begin, the facility must submit the original of the Long Term Care Assessment form (LTC-300) to LOCEU. Required attachments include current (within 90 days of requested approval date) medical information signed by a physician, a current (within 12 months of requested approval date) psychological evaluation, a copy of the pertinent section of the Individual Developmental Plan or other appropriate documentation relative to discharge planning and the need for ICF/MR level of care, and a statement that the client is not an

**MEDICAL PROVIDERS-FEE FOR SERVICE
LONG TERM CARE
FACILITIES SPECIFIC**

OAC 317:30-5-123 p(8)

imminent threat of harm to self or others (i.e., suicidal or homicidal). If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on MEDATS.

(3) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship to disability has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4).

In such instances, LOCEU will render a decision on categorical relationship using the same definition as used by SSA. A follow-up is required by the OKDHS worker with the Social Security Administration to be sure that their disability decision agrees with the decision of LOCEU.

317:30-5-131.2. Quality of care fund requirements and report

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

(1) **"Nursing Facility and Intermediate Care Facility for the mentally retarded"** means any home, establishment, or institution or any portion thereof, licensed by the State Department of Health as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.

(2) **"Quality of Care Fee"** means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for the mentally retarded licensed in this State.

(3) **"Quality of Care Fund"** means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(4) **"Quality of Care Report"** means the monthly report developed by the Oklahoma Health Care Authority to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for the mentally retarded licensed in the State.

(5) **"Staffing ratios"** means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(6) **"Peak In-House Resident Count"** means the maximum number of in-house residents at any point in time during the applicable shift.

(7) **"Staff Hours worked by Shift"** means the number of hours worked during the applicable shift by direct-care staff.

(8) **"Direct-Care Staff"** means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for the mentally retarded pursuant to Section 1-1925.2 of Title 63 of the

Oklahoma Statutes, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.

(9) **"Major Fraction Thereof"** is defined as an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.

(10) **"Minimum wage"** means the amount paid per hour to specified staff pursuant to Section 5022.1 of Title 63 of the Oklahoma Statutes.

(11) **"Specified staff"** means the employee positions listed in the Oklahoma Statutes under Section 5022.1 of Title 63 and as defined in subsection (d) of this Section.

(12) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(13) **"Total Gross Receipts"** means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, Private Pay and Insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.

(14) **"Service rate"** means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(b) Quality of care fund assessments.

(1) The Oklahoma Health Care Authority (OHCA) was mandated by the Oklahoma Legislature to assess a monthly service fee to each Licensed Nursing Facility in the State. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.

(2) In determination of the fee for the time period beginning October 1, 2000, a survey was mailed to each licensed nursing

**MEDICAL PROVIDERS-FEE FOR SERVICE
LONG TERM CARE FACILITIES SPECIFIC**

OAC 317:30-5-131.2 (p3)

facility requesting calendar year 1999 Total Patient Days, Gross Revenues and Contractual Allowances and Discounts. This data is used to determine the amount of fee to be assessed for the period of 10-01-00 through 06-30-01. The fee is determined by totaling the "annualized" gross revenue and dividing by the "annualized" total days of service. "Annualized" means that the surveys received that do not cover the whole year of 1999 are divided by the total number of days that are covered and multiplied by 365.

(3) The fee for subsequent State Fiscal Years is determined by using the monthly gross receipts and census reports for the six month period October 1 through March 31 of the prior fiscal year, annualizing those figures, and then determining the fee as defined above.

(4) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

(5) The method of collection is as follows:

(A) The Oklahoma Health Care Authority assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The Oklahoma Health Care Authority notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the Oklahoma Health Care Authority by the 10th of the following month. Failure to pay the amount by the 10th or failure to have the payment mailing postmarked by the 8th will result in a debt to the State of Oklahoma and is subject to penalties of 10% of the amount and interest of 1.25% per month. The Quality of Care Fee must be submitted no later than the 10th of the month. If the 10th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m. (Central Standard Time) of the following business day (Monday-Friday).

(C) The monthly assessment including applicable penalties and interest must paid regardless of any appeals action requested

by the facility. If a provider fails to pay the Authority the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for Oklahoma Health Care Authority Cost Reporting purposes.

(E) The Quality of Care fund contains assessments collected excluding penalties and interest as described in this subsection and any interest attributable to investment of any money in the fund must be deposited in a revolving fund established in the State Treasury. The funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) Quality of care direct-care-staff-to resident-ratios.

(1) Effective September 1, 2000, all nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-care-staff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

- (A) Registered Nurse
- (B) Licensed Practical Nurse
- (C) Nurse Aide
- (D) Certified Medication Aide
- (E) Qualified Mental Retardation Professional (ICFs/MR only)
- (F) Physical Therapist

- (G) Occupational Therapist
- (H) Respiratory Therapist
- (I) Speech Therapist
- (J) Therapy Aide/Assistant
- (K) Social Services Director/Social Worker
- (L) Other Social Services Staff
- (M) Activities Director
- (N) Other Activities Staff
- (O) Combined Social Services/Activities

(3) Prior to September 1, 2003, activity and social services staff who are not providing direct, hands-on care may be included in the direct-care-staff-to-resident ratio in any shift or direct-care service rates. On and after September 1, 2003, such persons are not included in the direct-care-staff-to-resident ratio or direct-care service rates.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and intermediate care facilities for the mentally retarded must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

(d) **Quality of care minimum wage for specified staff.** Effective November 1, 2000, all nursing facilities and private intermediate care facilities for the mentally retarded receiving Medicaid payments, in addition to other federal and state regulations, must pay specified staff not less than in the amount of \$6.65 per hour. Employee positions included for purposes of minimum wage for specified staff are as follows:

- (1) Registered Nurse

- (2) Licensed Practical Nurse
- (3) Nurse Aide
- (4) Certified Medication Aide
- (5) Other Social Service Staff
- (6) Other Activities Staff
- (7) Combined Social Services/Activities
- (8) Other Dietary Staff
- (9) Housekeeping Supervisor and Staff
- (10) Maintenance Supervisor and Staff
- (11) Laundry Supervisor and Staff

(e) **Quality of care reports.** Effective September 1, 2000, all nursing facilities and intermediate care facilities for the mentally retarded must submit a monthly report developed by the Oklahoma Health Care Authority, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report must be signed by the preparer and by the Owner, authorized Corporate Officer or Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, "*Whoever... (2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefit or payment... shall (i) in the case of such statement, representation, concealment, failure, or conversion*

**MEDICAL PROVIDERS-FEE FOR SERVICE
LONG TERM CARE FACILITIES SPECIFIC**

OAC 317:30-5-131.2 (p7)

by any person in connection with furnishing (by that person) of items or services for which payment is or may be made under this title (42 U.S.C. '1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both."

(4) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an electronic version for uniform submission of the required data elements.

(6) Facilities must submit the monthly report either through electronic mail to the Provider Compliance Audits Unit or send the monthly report in disk or paper format by certified mail and pursuant to subsection (e)(14) of this section. The submission date is determined by the date and time recorded through electronic mail or the postmark date and the date recorded on the certified mail receipt.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the Provider Compliance Audits Unit written notification with adequate, objective and substantive documentation within five business days following the submission deadline. Any documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the Oklahoma Health Care Authority.

(8) An initial administrative penalty of \$150.00 is imposed upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the Authority notifying the facility in writing that the report was not complete or not timely submitted as required. The \$150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For 100% private pay facilities,

the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: staffing ratios; peak in-house resident count; staff hours worked by shift; total patient days; total gross receipts; and direct-care service rates.

(10) Audits may be performed to determine compliance pursuant to subsections (b), (c) and (d) of this Section. Announced/unannounced on-site audits of reported information may also be performed.

(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the Oklahoma State Department of Health for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The Oklahoma State Department of Health informs the Oklahoma Health Care Authority of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(12) If a Medicaid provider is found non-compliant pursuant to subsection (d) based upon a desk audit and/or an on-site audit, for each hour paid to specified staff that does not meet the regulatory minimum wage of \$6.65, the facility must reimburse the employee(s) retroactively to meet the regulatory wage for hours worked. Additionally, an administrative penalty of \$25.00 is imposed for each non-compliant staff hour worked. For Medicaid facilities, a deduction is made to their payment. Imposed penalties for non-compliance with minimum wage requirements are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(13) Long Term Care facility providers may appeal the administrative penalty described in (b)(5)(B) and (e)(8) and (e)(12) of this section.

**MEDICAL PROVIDERS-FEE FOR SERVICE
LONG TERM CARE FACILITIES SPECIFIC**

OAC 317:30-5-131.2 (p9)

(14) Facilities that have been authorized by the Oklahoma State Department of Health (OSDH) to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility are required to complete the flexible staff scheduling section of Part A of the Quality of Care Report. The Owner, authorized Corporate Officer or Administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for Flexible Staff Scheduling.

317:30-5-700. Orthodontic services

(a) The Oklahoma State Medicaid Program limits orthodontic services to handicapping malocclusions determined to be severe enough to warrant medically necessary treatment. These orthodontic services include the following:

- (1) a handicapping malocclusion, as measured on the Handicapping Labio-Lingual Deviation Index (HLD) with a minimum score of 26; and
- (2) any classification secondary to cleft palate or other maxillofacial deformity.

(b) Reimbursement for Orthodontic services is limited to:

- (1) Orthodontists, or
- (2) General or Pediatric dental practitioners who have completed at least 200 hours of continuing education in the field of orthodontics; and successfully completed at least 25 comprehensive cases to include 10 or more extraction cases.
 - (A) As with all dental or orthodontia treatment performed and reimbursed by Medicaid, all pre and post orthodontic records must be available for review.
 - (B) Verification of the continuing education hours and the number of cases completed are reviewed by the OHCA Dental Unit every two years.

(c) The following limitations apply to orthodontic services:

- (1) Cosmetic orthodontic services are not a covered benefit of the Oklahoma State Medicaid Program;
- (2) All orthodontic procedures require prior authorization for payment;
- (3) Prior authorization for orthodontic treatment is not a notification of the patient's eligibility and does not guarantee payment. Payment for authorized services will depend on the client's eligibility at the beginning of each treatment year;

(4) The client must be Medicaid-eligible and under 21 years of age at the time the request for prior authorization for treatment is received by OHCA and on the date that the last year of orthodontic service is to begin. Services cannot be added or approved after eligibility has expired:

(A) Clients receive a permanent Medical Identification Card;

(B) It is the orthodontist's responsibility to verify that the patient has current Medicaid eligibility and that the date of birth indicates the client is under age 21. If no card is available, case status can be verified by utilizing the REVS system.

(d) Orthodontic services are an elective procedure. The orthodontist must interview the prospective patient as to his/her understanding of and willingness to cooperate fully in a lengthy treatment program.

(e) The interview information is unavailable to OHCA except through the provider's recommendation of treatment. The interview process for OHCA clients is equivalent to that of private pay patients.

(f) Providers are not obligated to accept a client when it appears that the client will not cooperate in the orthodontic treatment program or is not willing to keep eligibility current.

**MEDICAL ASSISTANCE FOR ADULTS
AND CHILDREN-ELIGIBILITY**

OAC 317:35-19-14

317:35-19-14. New admissions, readmissions, interfacility transfers, and same level of care program transfers

The Preadmission Screening process does not apply to readmission of an individual to an NF after transfer for a continuous hospital stay, and then back to the NF. There is no specific time limit on the length of absence from the nursing facility for the hospitalization. Inter-facility transfers are subject to resident reviews rather than preadmission screening. In the case of transfer of a resident from an NF to a hospital, another NF, or to Home and Community Base Waiver services, the transferring NF is responsible for ensuring that copies of the resident's most recent PASRR LTC-300A, resident assessment reports, and any PASRR evaluations accompany the transferring resident. The receiving NF must submit an updated LTC-300A that reflects the resident's current status to LOCEU within 30 days of the transfer. Failure to do so could result in possible recoupment of funds.