
POLICY TRANSMITTAL NO. 10-09	DATE: MARCH 17, 2010
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF INTERGOVERNMENTAL RELATIONS AND POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-3-5; 30-3-57; 30-3-62; 30-5-14; 30-5-24; 30-5-42.1; 30-5-72; 30-5-211.10; 30-5-211.12; 30-5-211.15; 30-5-218; 30-5-547; 30-5-1040 through 30-5-1044; 30-5-1046 through 30-5-1047; 35-5-25; and 35-6-60 through 35-6-61.

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

Agency rules are revised to increase co-payments for certain medical services provided through SoonerCare. Under Section 1902(a)(14) of the Social Security Act, States are permitted to require certain members to share some of the cost of their health care by imposing upon them such payments as enrollment fees, premiums, deductibles, co-insurance, co-payments, or similar cost sharing charges. The Centers for Medicare and Medicaid Services excludes the States from requiring cost sharing for children, pregnant women and institutionalized individuals as well as for emergency and family planning services. According to Article 10, Section 23 of the Oklahoma Constitution, all state agencies must maintain a balanced budget. In order for the Agency to accomplish the necessary financial reductions, rules are in need of revision to increase the existing co-payments for some services for certain SoonerCare members.

Agency rules are revised to change the script limit for SoonerCare members from three brand drugs and three generic to two brand drugs and four generic. The revisions are needed in order to reduce the Agency's budget to comply with the legislative mandated budget reductions.

Agency rules are written to establish policy for serious reportable events in healthcare, also called never events. Rules will non-cover three surgical errors and set billing policy to implement appropriate claims processing. The three surgical errors are (1) wrong surgical or other invasive procedures performed on a member, (2) surgical or other invasive procedures performed on the wrong body part, and (3) surgical or other invasive procedures performed on the wrong

member. Rules will also include a related claims review (if appropriate) and the avoidance of SoonerCare to act as a secondary payer for Medicare non-payment of the three surgical errors.

Agency rules are revised to comply with CMS SHO #09-111 requiring all State Medicaid agencies to reimburse a vaccine administration fee to all Medicaid contracted providers administering the 2009 H1N1 vaccine to eligible populations. Currently, rules only allow for reimbursement for vaccine administration in limited circumstances. Revisions allow for reimbursement of an administration fee for pandemic virus vaccines administered to eligible SoonerCare members following a declaration by the Centers for Disease Control of a pandemic virus. Revisions also allow for an administration fee to be paid to providers administering the Human Papillomavirus (HPV) vaccine to eligible SoonerCare members.

Outpatient hospital rules are revised to clarify the intent of reimbursement for implantable devices inserted during the course of a surgical procedure. Separate payment will be made for implantable devices, but only when the implantable device is not included in the rate for the procedure to insert the device. Additional revisions include removing all-inclusive reimbursement language for outpatient radiological services and additional clarification in regards to adult therapies performed in an outpatient hospital based setting.

Durable medical equipment (DME) rules are revised to reduce and/or eliminate certain durable medical equipment benefits to adults in order to comply with the budget reductions mandated by the Oklahoma Legislature through the end of State Fiscal Year 2010. Revisions include the elimination of osteogenic stimulators, portable oxygen contents, the reduction of blood glucose strips and lancets without a prior authorization, and flexibility in the agency's reimbursement terminology.

Agency rules are revised to change the status of the Office of Juvenile Affairs from an Organized Health Care Delivery System to a Foster Care Agency. The revisions are needed in order to maintain current levels of reimbursement after OJA's Targeted Case Management (TCM) Services were affected by the CMS final rule regarding TCM Services, CMS-2237-IFC. Rules are also revised to reduce the number of beds in Residential Behavioral Management Services (RBMS) homes to 16 or less in order for the homes to not be considered "public institutions" and risk loss of federal financial participation for the services currently provided in the homes to SoonerCare members.

SoonerCare eligibility rules regarding coverage for deemed newborns are revised to comply with provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3. The Deficit Reduction Act of 2005 added specific citizenship and identity documentation requirements in order for individuals to qualify for Medicaid. Public Law 111-3 provides that children who were initially eligible for Medicaid as deemed newborns shall be considered to have provided satisfactory documentation of citizenship and identity when their eligibility is renewed on their first birthday. The legislation further eliminates the requirement that, in order to receive coverage, newborns coming home from the hospital must live with the mother, remain a member of the mother's household, and that the mother remain eligible for Medicaid (or would remain eligible if still pregnant). Rules are revised to state that a deemed newborn will be regarded as meeting the citizenship and identity requirements for all future SoonerCare eligibility determinations. Further, the certification period for the deemed newborn will be shortened only in the event the child loses Oklahoma residence or expires. Other revisions clarify that deemed newborns are to be certified for SoonerCare through the end of the month that the child reaches age one.

Original signed on 3-16-10

Mary Stalnaker, Director
Family Support Services Division

Sandra Harrison, Coordinator
Office of Intergovernmental Relations and
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WF # 10-D (NAP)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

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

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

<u>REMOVE</u>	<u>INSERT</u>
317:30-3-5	317:30-3-5, pages 1-3; revised 1-14-10
317:30-3-57	317:30-3-57, pages 1-5, revised 1-14-10
-----	317:30-3-62, pages 1-2, issued 1-14-10
317:30-5-14	317:30-5-14, pages 1-2, revised 1-14-10
317:30-5-24	317:30-5-24, pages 1-2, revised 1-14-10
317:30-5-42.1	317:30-5-42.1, 1 page only, revised 1-14-10
317:30-5-72	317:30-5-72, pages 1-2, revised 1-14-10
317:30-5-211.10	317:30-5-211.10, 1 page only, revised 1-14-10
317:30-5-211.12	317:30-5-211.12, 1 page only, revised 1-14-10
317:30-5-211.15	317:30-5-211.15, 1 page only, revised 1-14-10
317:30-5-218	317:30-5-218, 1 page only, revised 1-14-10
317:30-5-547	317:30-5-547, 1 page only, revised 1-14-10
317:30-5-1040	317:30-5-1040, 1 page only, revised 1-14-10
317:30-5-1041	317:30-5-1041, 1 page only, revised 1-14-10
317:30-5-1042	317:30-5-1042, 1 page only, revised 1-14-10
317:30-5-1043	317:30-5-1043, pages 1-8, revised 1-14-10

REMOVE

317:30-5-1044

317:30-5-1046

317:30-5-1047

317:35-5-25

317:35-6-60

317:35-6-61

INSERT

317:30-5-1044, 1 page only, revised 1-14-10

317:30-5-1046, 1 page only, revised 1-14-10

317:30-5-1047, 1 page only, revised 1-14-10

317:35-5-25, pages 1-9, revised 1-14-10

317:35-6-60, pages 1-3, revised 1-14-10

317:35-6-61, 1 page only, revised 1-14-10

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

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

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

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

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

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

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

(2) Once an assigned claim has been filed, the member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Provider Services.

(3) When potential assignment violations are detected, the OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the OHCA is required to suspend further payment to the provider.

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

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

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

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

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

(1) Co-payment is not required of the following members:

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

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

(C) Pregnant women.

(D) Home and Community Based Service waiver members except for prescription drugs.

(2) Co-payment is not required for the following services:

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

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

(3) Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

- (C) Ambulatory surgery visits including free-standing ambulatory surgery centers.
- (D) Encounters with the following rendering providers:
 - (i) Physicians,
 - (ii) Advanced Practice Nurses,
 - (iii) Physician Assistants,
 - (iv) Optometrists,
 - (v) Home Health Agencies,
 - (vi) Certified Registered Nurse Anesthetists, and
 - (vii) Anesthesiologist Assistants,
 - (viii) Durable Medical Equipment providers, and
 - (ix) Outpatient behavioral health providers.
- (E) Prescription drugs.
 - (i) Zero for preferred generics
 - (ii) \$2.00 for prescriptions having a SoonerCare allowable of \$29.99 or less.
 - (iii) \$3.00 for prescriptions having a SoonerCare allowable of \$30.00 or more.
- (F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.

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

The following are general SoonerCare coverage guidelines for the categorically needy:

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

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

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

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

(C) Immunizations.

(D) Outpatient care.

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

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

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

(H) Prescribed drugs.

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

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

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

(L) Inpatient hospital services.

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

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

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

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a nursing facility, ICF/MR, or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are

limited to four per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

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

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

(17) Free-standing ambulatory surgery centers.

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

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

(B) seven medically necessary generic prescriptions per month in addition to the six covered under the State Plan are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. These additional medically necessary prescriptions beyond the two brand name or thirteen total prescriptions are covered with prior authorization.

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

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

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

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

(23) Standard medical supplies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (37) Home and community-based waiver services for mentally retarded members who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).
- (38) Case Management services for the chronically and/or severely mentally ill.
- (39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.
- (40) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.
- (41) Early Intervention services for children ages 0-3.
- (42) Residential Behavior Management in therapeutic foster care setting.
- (43) Birthing center services.
- (44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services.
- (45) Home and Community-Based Waiver services for aged or physically disabled members.
- (46) Outpatient ambulatory services for members infected with tuberculosis.
- (47) Smoking and Tobacco Use Cessation Counseling for children and adults.
- (48) Services delivered to American Indians/Alaskan Natives in I/T/Us. Payment is made on an encounter basis.
- (49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

317:30-3-62. Serious reportable events - never events

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

(1) **"Surgical and other invasive procedures"** are defined as operative procedures in which skin or mucous membranes and connective tissues are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

(2) A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that member.

(3) A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that member including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).

(4) A surgical or other invasive procedure is considered to have been performed on the wrong member if that procedure is not consistent with the correctly documented informed consent for that member.

(b) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs (1) a different procedure altogether; (2) the correct procedure but on the wrong body part; or (3) the correct procedure but on the wrong member. SoonerCare will not cover hospitalizations or any services related to these non-covered procedures. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are also not eligible for payment. All related services provided during the same

hospitalization in which the error occurred are not covered. A provider cannot shift financial liability or responsibility for the non-covered services to the member if the OHCA has determined that the service is related to one of the above erroneous surgical procedures.

(c) **Billing.** For inpatient claims, hospitals are required to bill two claims when the erroneous surgery is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services or procedures as a no-payment claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS modifiers to all lines related to the erroneous surgery. Claim lines submitted with one of the applicable HCPCS modifiers will be line-item denied.

(d) **Related claims.** Once a claim for the erroneous surgery(s) has been received, OHCA may review member history for related claims as appropriate. Incoming claims for the identified member may be reviewed for an 18-month period from the date of the surgical error. If such claims are identified to be related to the erroneous surgical procedure(s), OHCA may take appropriate action to deny such claims and recover any overpayments on claims already processed.

(e) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned erroneous surgery(s).

317:30-5-14. Injections

(a) Coverage for injections is limited to those categories of drugs included in the vendor drug program for SoonerCare. SoonerCare payment is not available for injectable drugs whose manufacturers have not entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS). OHCA administers and maintains an open formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) subject to the exclusions and limitations provided in OAC 317:30-5-72.1.

(1) **Immunizations for children.** An administration fee will be paid for vaccines administered by providers participating in the Vaccines for Children Program. When the vaccine is not included in the program, the administration fee is included in the vaccine payment. Payment will not be made for vaccines covered by the Vaccines for Children Program.

(2) **Immunizations for adults.** Coverage for adults is provided as per the Advisory Committee on Immunization Practices (ACIP) guidelines. A separate payment will not be made for the administration of a vaccine unless specifically outlined in policy. The administration fee is included in the vaccine payment.

(b) Providers must use the appropriate HCPCS code and National Drug Code (NDC). In addition to the NDC and HCPCS code, claims must contain the drug name, strength, and dosage amount.

(c) Payment is made for allergy injections for adults and children. When the contracted provider actually administers or supervises the administration of the injection, the administration fee is compensable. No payment is made for administration when the allergy antigen is self-administered by the member. When the allergy antigen is purchased by the physician, payment is made by invoice attached to the claim.

(d) Rabies vaccine, Imovax, Human Diploid and Hyperab, Rabies Immune Globulin are covered under the vendor drug program and may be covered as one of the covered prescriptions per month. Payment can be made separately to the physician for administration. If the vaccine is purchased by the physician, payment is made by invoice attached to the claim.

(e) Human Papillomavirus (HPV) vaccine is approved and covered under guidelines established by the ACIP for children and adults. Payment can be made separately to the physician for administration and the vaccine product.

(f) Trigger point injections (TPI's) are covered using appropriate CPT codes. Modifiers are not allowed for this code. Payment is

made for up to three injections (3 units) per day at the full allowable. Payment is limited to 12 units per month. The medical records must clearly state the reasons why any TPI services were medically necessary. All trigger point records must contain proper documents and be available for review. Any services beyond 12 units per month or 36 units per 12 months will require mandatory review for medical necessity. Medical records must be automatically submitted with any claims for services beyond 36 units.

(g) If a physician bills separately for surgical injections and identifies the drugs used in a joint injection, payment will be made for the cost of the drug in addition to the surgical injection. The same guidelines apply to aspirations.

(h) When IV administration in a Nursing Facility is filed by a physician, payment may be made for medication. Administration should be done by nursing home personnel.

(i) Intravenous fluids used in the administration of IV drugs are covered. Payment for the set is included in the office visit reimbursement.

(j) In the event a pandemic virus is declared by the Centers for Disease Control (CDC) and/or the Department of Health & Human Services, an administration fee will be paid to providers for administering the pandemic virus vaccine to adults and children as authorized by the Centers for Medicare and Medicaid Services (CMS).

317:30-5-24. Radiology**(a) Outpatient and emergency department.**

(1) The technical component of outpatient radiological services performed during an emergency department visit is covered.

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

(3) Ultrasounds for obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b)(2)(A-C).

(4) Payment is made for charges incurred for the administration of chemotherapy for the treatment of medically necessary and medically approved procedures. Payment for radiation therapy is limited to the treatment of proven malignancies and benign conditions appropriate for stereotactic radiosurgery (e.g., gamma knife).

(5) Medically necessary screening mammography is a covered benefit. Additional follow-up mammograms are covered when medically necessary.

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

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

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

(e) Miscellaneous.

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

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

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

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

- (5) **Supplies.** Separate payment is not made for supplies such as "administration set" used in provision of office chemotherapy.
- (6) **Fluoroscopy or Esophagus study.** Separate charge for fluoroscopy or esophagus study in addition to a routine gastrointestinal tract examination is not covered unless a report is submitted indicating an esophagram was done as a separate procedure.
- (f) **Magnetic Resonance Imaging.** MRI/MRA scans are covered when medically necessary. Documentation in the progress notes must reflect the medical necessity. The diagnosis code must be shown on the claim.
- (g) **Placement of radium or other radioactive material.**
- (1) For Radium Application use the appropriate HCPCS code.
 - (2) When a physician supplies the therapeutic radionuclides (implant grains or Gold Seeds) and provides a copy of the invoice, payment is made at 100% of the invoice charges. Fee must include cost of radium, container, and shipping and handling.

317:30-5-42.1. Outpatient hospital services

(a) Hospitals providing outpatient hospital services are required to meet the same requirements that apply to OHCA contracted, non-hospital providers performing the same services. Outpatient services performed outside the hospital facility are not reimbursed as hospital outpatient services.

(b) Covered outpatient hospital services must meet all of the criteria listed in (1) through (4) of this subsection.

(1) The care is directed by a physician or dentist.

(2) The care is medically necessary.

(3) The member is not an inpatient.

(4) The service is provided in an approved hospital facility.

(c) Covered outpatient hospital services are those services provided for a member who is not a hospital inpatient. A member in a hospital may be either an inpatient or an outpatient, but not both (see OAC 317:30-5-41).

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

(e) Physical, occupational, and speech therapy services are covered when performed in an outpatient hospital based setting. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year. Claims for these services must include the appropriate revenue code(s).

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 two 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 915(c) Home and Community Based Services Waivers. Medically necessary prescriptions beyond the two brand name or thirteen total prescriptions will be covered with prior authorization.

(3) Drugs exempt from the prescription limit include: Antineoplastics, anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV), certain prescriptions that require frequent laboratory monitoring, birth control prescriptions, over the counter contraceptives, hemophilia drugs, compensable smoking cessation products, low-phenylalanine formula and amino acid bars for persons with a diagnosis of PKU, certain carrier or diluent 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 SoonerCare 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 also eligible for the Medicare Part D prescription drug benefit. Coordination of benefits between Medicare Part B and Medicare Part D is the responsibility of the pharmacy provider. The SoonerCare pharmacy benefit does not include any products which are available through either Part B or Part D of Medicare.

(d) **Individuals eligible for a prescription drug benefit through a**

Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003. Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. The exclusion will become effective January 1, 2006, or the date Medicare Part D is implemented for dual eligible individuals, whichever is later. This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

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

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

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

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

(c) **Prior authorization.**

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

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

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

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

317:30-5-211.12. Oxygen rental

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

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

(2) For members who meet medical necessity criteria, SoonerCare covers portable liquid or gaseous oxygen systems. Portable oxygen contents are not covered. The need for a portable oxygen system must be stated on the CMN. A portable system that is used as a backup system only is not a covered item.

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

317:30-5-211.15. Supplies

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

(b) Special requirements:

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

(2) **Diabetic supplies.** A maximum of 100 glucose test strips and 100 lancets per month when medically necessary and prescribed by a physician are covered items. Diabetic supplies in excess of these parameters must be prior authorized.

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

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

317:30-5-218. Reimbursement

(a) **Medical equipment and supplies.** Reimbursement for durable medical equipment and supplies will be made using an amount derived from the lesser of the OHCA maximum allowable fee or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established. The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

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

(1) Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. Ownership of the equipment remains with the supplier.

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

(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. Reimbursement for members who reside in a nursing facility may be at a reduced rate. The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

317:30-5-547. Reimbursement

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

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

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

(1) Payment for oxygen systems (stationary, liquid and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are also considered continuous rental. Ownership of the equipment remains with the supplier.

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

(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. Reimbursement for members who reside in a nursing facility may be at a reduced rate. The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

317:30-5-1041. Eligible providers

Payment is made for Residential Behavior Management Services (RBMS) provided in private group settings and non-secure Diagnostic and Evaluation (D&E) Centers with 16 beds or less. All providers eligible for reimbursement under this section must be a legally recognized Foster Care Agency (FCA) in the State of Oklahoma and have a contract on file with the Oklahoma Health Care Authority. Employees and contractors of the FCA who furnish each covered service must meet the State's minimum qualifications for its provision. All services must be prior authorized by the Oklahoma Department of Human Services (OKDHS) or the Office of Juvenile Affairs (OJA).

317:30-5-1042. Memorandum of agreement

A Memorandum of Agreement between the Oklahoma Health Care Authority and the Foster Care Agency (FCA) must be in effect before reimbursement can be made for compensable services. The agreement outlines the contractual and sub-contractual requirements for reimbursement.

317:30-5-1043. Coverage by category

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

(b) **Children.** Residential Behavioral Management Services 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 Foster Care Agencies (FCA) 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 child is placed. Members 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. Members residing in a Level D+ Group Home receive highly intensive supervision and treatment. Members residing in a Level D Group Home receive close supervision and moderate treatment. Members residing in a Level C Group Home receive minimum supervision and treatment. Members residing in Residential Diagnostic and Evaluation Centers receive intensive supervision and a 20 day comprehensive assessment. Members residing in a Sanctions Home receive highly intensive supervision and treatment. Members 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 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 FCA collaborates 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 are funded in the normal manner. The FCA must

provide concurrent documentation that these services are not duplicative. The OHCDSD determines 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 FCA 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.

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

(3) **Treatment components.**

(A) **Individual plan of care development.** A comprehensive individualized plan of care 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 must 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 individual plan of care by the agency which has permanent or temporary custody of the child and indicated by the signature of the agency case worker or liaison on the individual plan of care. It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature; however, the

provider obtains the original signature for the clinical file within 30 days. No stamped or photo copied signatures are allowed. An individual plan of care is considered inherent in the provision of therapy and is not covered as a separate item of behavior management services. The individual plan of care 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 member's individual plan of care must 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 educational placement services. (Any educational costs are excluded from calculation of the daily rate for behavior management services.)

(B) **Individual therapy.** The provider agency must 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 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. Members 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 plan of care. 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 must 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 plan of care. The minimum expected occurrence would be one hour per week in Level D, Level C, 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.

One half hour of individual therapy may be substituted for one hour of group therapy.

(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 must provide family therapy as indicated by the resident's individual plan of care. The agency must work with the caretaker to whom the resident will be discharged, as identified by the FCA custody worker. The agency must 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 must 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 must 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 is 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 must 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 individual plan of care. This may include 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 must 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 plan of care. 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 must be able to provide behavior redirection management by agency staff as needed 24 hours a day, 7 days per week. The agency must 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 provider 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,
- (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 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.

(5) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services provided by their staff for behavior management therapies (Individual, Group, Family) as of July 1, 2007, 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, alcohol and drug counselor 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.

(D) Staff providing basic living skills redevelopment, social skills redevelopment, and alcohol and other substance abuse treatment, must 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, alcohol and drug; or
- (ii) a current license as a registered nurse in Oklahoma; or
- (iii) certification as an Alcohol and Drug Counselor to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DMS-IV 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.

(E) Staff providing behavior redirection services must have current certification and required updates in nationally recognized behavior management techniques, such as Controlling Aggressive Patient Environment (CAPE) or MANDT. Additionally, staff providing these services must receive initial and ongoing training in at least one of the following areas:

- (i) trauma informed methodology,
- (ii) anger management,
- (iii) crisis intervention,
- (iv) normal child and adolescent development and the effect of abuse,
- (v) neglect and/or violence on such development,
- (vi) grief and loss issues for children in out of home placement,
- (vii) interventions with victims of physical, emotional and sexual abuse,
- (viii) care and treatment of children with attachment disorders,
- (ix) care and treatment of children with hyperactive, or attention deficit, or conduct disorders,
- (x) care and treatment of children, youth and families with substance abuse and chemical dependency disorders,

(xi) passive physical restraint procedures,
(xii) procedures for working with delinquents or the
Inpatient Mental Health and Substance Abuse Treatment of
Minors Act.

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

317:30-5-1044. Payment rates

Payment is made at the lower of the provider=s usual and customary charge or the OHCA fee schedule for SoonerCare compensable services.

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

(a) The FCA and the facilities with whom it contracts must maintain appropriate records system. Current individual plans of care, 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 FCA 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 patients' 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 individualized plan of care);
- (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.

317-30-5-1047. Confidentiality of information

In accordance with the provisions of 42 CFR 431, Subpart F, the FCA and the facilities with whom it contracts must safeguard information about the member.

317:35-5-25. Citizenship/alien status and identity verification requirements

(a) **Citizenship/alien status and identity verification requirements.** Verification of citizenship/alien status and identity are required for all adults and children approved for SoonerCare. An exception is individuals who are initially eligible for SoonerCare as deemed newborns; according to Section 1903(x) of the Social Security Act, they will not be required to further document citizenship or identity at any subsequent SoonerCare eligibility redetermination. They are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States.

(1) The types of acceptable evidence that verify identity and citizenship include:

(A) United States (U.S.) Passport; ■ 1

(B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS) (Form N-550 or N-570);

(C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561);

(D) Copy of the Medicare card or printout of a BENDEX or SDX screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; ■ 2 or

(E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual.

(2) The types of acceptable evidence that verify citizenship but require additional steps to obtain satisfactory evidence of identity are listed in subparagraphs (A) and (B). Subparagraph (A) lists the most reliable forms of verification and is to be used before using items listed in (B). Subparagraph (B) lists those verifications that are less reliable forms of verification and are used only when the items in (A) are not attainable. ■ 3

(A) Most reliable forms of citizenship verification are:

(i) A U.S. public Birth Certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986;

(ii) A Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of birth issued by the State Department (Form FS-240, FS-545 or DS-1350);

(iii) A U.S. Citizen ID Card (Form I-179 or I-197);

(iv) A Northern Mariana Identification Card (Form I-873)

(Issued by the INS to a collectively naturalized citizen

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of the U.S. who was born in the Northern Mariana Islands before 11/3/1986);

(v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);

(vi) A Final Adoption Decree showing the child's name and U. S. place of birth;

(vii) Evidence of U.S. Civil Service employment before 6/1/1976;

(viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);

(ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;

(x) Oklahoma Voter Registration Card; or

(xi) Other acceptable documentation as approved by OHCA.

(B) Other less reliable forms of citizenship verification are:

(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five years before the initial application date and that indicates a U.S. place of birth. For children under 16 the evidence must have been created near the time of birth or five years before the date of application;

(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five years before the initial application date and that indicates a U.S. place of birth;

(iii) Federal or State census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or

(iv) One of the following items that show a U.S. place of birth and was created at least five years before the application for SoonerCare. This evidence must be one of the following and show a U.S. place of birth:

(I) Seneca Indian tribal census record;

(II) Bureau of Indian Affairs tribal census records of the Navajo Indians;

(III) U.S. State Vital Statistics official notification of birth registration;

(IV) An amended U.S. public birth record that is amended more than five years after the person's birth; or

(V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:

(A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;

(B) A school identification card with a photograph of the individual;

(C) An identification card issued by Federal, state, or local government with the same information included on driver's licenses;

(D) A U.S. military card or draft record;

(E) A U.S. military dependent's identification card;

(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;

(G) A U.S. Coast Guard Merchant Mariner card;

(H) A state court order placing a child in custody as reported by the OKDHS;

(I) For children under 16, school records may include nursery or daycare records;

(J) If none of the verification items on the list are available, an affidavit may be used for children under 16. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and **cannot be used if an affidavit for citizenship was provided.**

(b) Reasonable opportunity to obtain citizenship verification. ■ 4

(1) When the applicant/member is unable to obtain citizenship verification, a reasonable opportunity is afforded the applicant/member to obtain the evidence as well as assistance in doing so. A reasonable opportunity is afforded the applicant/member before taking action affecting the individual's eligibility for SoonerCare. The reasonable opportunity time frame usually consists of 60 days. In rare instances, the time frame may be extended to a period not to exceed an additional 60 days.

(2) The following methods of verification are the least reliable forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;

(B) Medical (clinic, doctor, or hospital) record created at least five years before the initial application date that indicates a U.S. place of birth. For children under 16, the document must have been created near the time of birth. Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship;

(C) Written affidavit. Affidavits are only used in rare circumstances. If the verification requirements need to be met through affidavits, the following rules apply:

(i) There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's/member's claim of citizenship;

(ii) At least one of the individuals making the affidavit cannot be related to the applicant/member;

(iii) In order for the affidavit to be acceptable the persons making them must be able to provide proof of their own citizenship and identity;

(iv) If the individual(s) making the affidavit has information which explains why evidence establishing the applicant's/member's claim or citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;

(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and

(vi) The affidavits must be signed under penalty of perjury.

(c) **Alienage verification requirements.** SoonerCare services are provided as listed to the defined groups as indicated in this subsection if they meet all other factors of eligibility. ■ 5

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ix) admitted as an Amerasian immigrant.

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

(2) **Other aliens lawfully admitted for permanent residence (non-qualified aliens).** Non-qualified aliens are those individuals who were admitted to the United States and who do not meet any of the definitions in paragraph (1) of this subsection. Non-qualified aliens are ineligible for SoonerCare for five years from the date of entry except that non-qualified aliens are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention. The only exception is when a pregnant woman

qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(3) **Afghan Special Immigrants.** Afghan special immigrants, as defined in Public Law 110-161, who have special immigration status after December 26, 2007, are exempt from the five year period of ineligibility for SoonerCare services for a time-limited period. The time-limited exemption period for Afghan special immigrants is eight months from the date of entry into the United States as a special immigrant or the date of conversion to special immigrant status. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Once the eight month exemption period ends, Afghan special immigrants are no longer exempt from the five year bar for SoonerCare services and are only eligible for services described in (2) of this subsection until the five year period ends. Afghan special immigrants are considered lawful permanent residents.

(4) **Iraqi Special Immigrants.** Iraqi special immigrants, as defined in Public Law 110-181, who have special immigration status after January 28, 2008, are exempt from the five year period of ineligibility for SoonerCare services for a time-limited period. The time-limited exemption period for Iraqi special immigrants is eight months from the date of entry into the United States as a special immigrant or the date of conversion to special immigrant status. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Once the eight month exemption period ends, Iraqi special immigrants are no longer exempt from the five year bar for SoonerCare services and are only eligible for services described in (2) of this subsection until the five year period ends. Iraqi special immigrants are considered lawful permanent residents.

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

Title XXI program because the newborn child will meet the citizenship requirement at birth.

(6) Ineligible aliens.

(A) Ineligible aliens who do not fall into the categories in (1) and (2) of this subsection, yet have been lawfully admitted for temporary or specified periods of time include, but are not limited to: foreign students, visitors, foreign government representatives, crewmen, members of foreign media and temporary workers including agricultural contract workers. This group is ineligible for SoonerCare, including emergency services, because of the temporary nature of their admission status. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

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

(7) Preauthorization. Preauthorization is required for payment of emergency medical services rendered to non-qualified and undocumented aliens. Persons determined as having lawful alien status must have the status verified through Systematic Alien Verification for Entitlements (SAVE).

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

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

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

(3) Refugees and Western Hemisphere aliens. Under Section 203(a)(7) of the Immigration and Nationality Act, Refugees and Western Hemisphere aliens may be lawfully admitted to the United States if, because of persecution or fear of prosecution due to

race, religion, or political opinion, they have fled from a Communist or Communist-dominated country or from the area of the Middle East; or if they are refugees from natural catastrophes.

These entries meet the citizenship and alienage requirement. Western Hemisphere aliens will meet the citizenship requirement for SoonerCare if they can provide either of the documents in subparagraphs (A) and (B) of this paragraph as proof of their alien status.

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

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

(4) **Special provisions relating to Kickapoo Indians.** Kickapoo Indians migrating between Mexico and the United States carry Form I-94, Arrival-Departure Record (Parole Edition). If Form I-94 carries the statement that the Kickapoo is "paroled pursuant to Section 212(d)(5) of the Immigration and Nationality Act" or that the "Kickapoo status is pending clarification of status by Congress" regardless of whether such statements are preprinted or handwritten and regardless of a specific mention of the "treaty", they meet the "citizenship and alienage" requirement. All Kickapoo Indians paroled in the United States must renew their paroled status each year at any local Immigration Office. There are other Kickapoos who have entered the United States from Mexico who carry Form I-151 or Form I-551, Alien Registration Receipt Cards. These individuals have the same status as other individuals who have been issued Form I-151 or Form I-551 and therefore, meet the citizenship and alienage requirements. Still other Kickapoos are classified as Mexican Nationals by the BCIS. They carry Form I-94, Arrival-Departure Record, which has been issued as a visiting visa and does not make mention of the treaty. Such form does not meet the "citizenship and alienage" requirements but provides only the ineligible alien status described in (c)(4)(b) of this Section. ■ 6

(5) **American Indians born in Canada.** An American Indian born in Canada, who has maintained residence in the United States since entry, is considered to be lawfully admitted for permanent residence if he/she is of at least one-half American Indian

blood. This does not include the non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50 percent or more Indian blood. The methods of documentation are birth or baptismal certificate issued on a reservation, tribal records, letter from the Canadian Department of Indian Affairs, or school records.

(6) **Permanent non-immigrants.** Marshall Islanders and individuals from the Republic of Palau and the Federated States of Micronesia are classified as permanent non-immigrants by BCIS. They are eligible for emergency services only.

INSTRUCTIONS TO STAFF

1. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. NOTE: spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented. EXCEPTION: Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.
2. Medicare and SSI recipients do not have to verify their citizenship and identity as they have previously been verified by SSA.
3. Verification should be placed in the case file and documented in case notes.
4. Designated OKDHS staff will have access to the OSDH web based verification system to verify record of Oklahoma birth. The birth record document must have been issued before the person was five years of age.
5. See OKDHS Appendix J, Citizenship and Alienage.
6. Verification issued by the Department of Homeland Security will identify U.S. citizen members of the Texas Band of Kickapoo Indians living near the U.S./Mexican border.

317:35-6-60. Certification for SoonerCare for pregnant women and families with children

An individual determined eligible for SoonerCare may be certified for a medical service provided on or after the first day of the month of application. The period of certification may not be for retroactive months. The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery and postpartum periods without regard to eligibility for other household members in the case. ■ 1

(1) **Certification as a TANF (cash assistance) recipient.** A categorically needy individual who is determined eligible for TANF is certified effective the first day of the month of TANF eligibility.

(2) **Certification of non-cash assistance individuals categorically needy and related to AFDC.** The certification period for the individual related to AFDC is 12 months. The certification period can be less than 12 months if the individual:

(A) is certified as eligible in a money payment case during the 12-month period;

(B) is certified for long-term care during the 12-month period;

(C) becomes ineligible for SoonerCare after the initial month; or

(D) becomes ineligible as categorically needy.

(i) If an income change after certification causes the case to exceed the categorically needy maximums, the case is closed.

(ii) Individuals, however, who are determined pregnant and eligible as categorically needy continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy related services through the postpartum period. ■ 2

(3) **Certification of individuals categorically needy and related to pregnancy-related services.** The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the two months following the month the pregnancy ends. Eligibility as categorically needy is based on the income received in the first month of the

certification period. No consideration is given to changes in income after certification.

(4) Certification of newborn child deemed eligible.

(A) Every newborn child is deemed eligible on the date of birth for SoonerCare when the child is born to a woman who is eligible for pregnancy-related services as categorically needy. The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one. The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.

(B) The newborn child is deemed eligible for SoonerCare as long as he/she continues to live in Oklahoma. No other conditions of eligibility are applicable, including social security number enumeration, child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to the Oklahoma Child Support Services (OCSS) division at OKDHS. The referral enables child support services to be initiated.

(C) When a categorically needy newborn child is deemed eligible for SoonerCare, he/she remains eligible through the end of the month that the newborn child reaches age one. If the child's eligibility is moved from the case where initial eligibility was established, it is required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:

- (i) loses Oklahoma residence;
- (ii) expires.

(D) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

INSTRUCTIONS TO STAFF

1. Certification procedures for a family case. Each individual to

be included in a family case is coded on the computer input document with the appropriate categorical relationship. Family cases may contain individuals who are categorically related to different categories. The countable income is shown on a monthly basis for each individual.

2. The procedure is to continue the services for the pregnant woman by certifying the D section. If the TANF case is still active for other members, the procedure is to continue the services by removing the TANF benefit and continue the health benefit.

**317:35-6-61. Redetermination of eligibility for persons receiving
SoonerCare**

A periodic redetermination of eligibility for SoonerCare is required on all categorically needy cases related to AFDC. The redetermination is made prior to the end of the initial certification period and each 12 months thereafter. A deemed newborn is eligible through the last day of the month the newborn child attains the age of one year, without regard to eligibility of other household members in the case.