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POLICY TRANSMITTAL NO. 09-48	DATE: AUGUST 24, 2009
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS AND POLICY

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TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:2-1-1 through 2-1-2; 2-1-6 through 2-1-13; 30-3-27;  
30-3-80; 30-5-1091; 35-5-25; and 45-11-11.

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

SoonerCare citizenship rules are revised to extend the time limited benefit period for Afghans with special immigrant status from six to eight months. Congress enacted Public Law 111-08 (Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act of 2009) on March 10, 2009, which lengthened the six month period of Medicaid for Afghan special immigrants to eight months. Rules are amended to assure that eligible Afghan individuals receive SoonerCare benefits for the correct period of time under federal regulation.

Oklahoma Health Care Authority (OHCA) rules are revised to add Indian Health Service Facilities, Tribally Operated Facilities and Urban Indian Clinics as distant site providers under the telemedicine delivery system, allowing segments of the Native American population in rural areas access to specialty healthcare services. Additionally this rule includes public health nursing as an allowable service available to qualifying individuals in the Native American population. Lower income Native Americans will benefit from this rule change as a result of improved access to specialty care services and public health nursing services.

OHCA rules are revised to include language regarding member and provider appeals processes, specifically concerning time frames allowed for responses to appeals from the Oklahoma Health Care Authority and the Administrative Law Judge. Additionally, the rule revision clarifies the process for administrative sanction appeals and the process for provider suspension or termination.

Durable medical equipment (DME) rules are revised to revoke an outdated DME policy related to oxygen and oxygen equipment and

the requirements for prior authorization. Current DME rules already clarify that no prior authorization is required for oxygen and oxygen equipment. Revoking this rule will alleviate confusion and make rules consistent.

Insure Oklahoma/O-EPIC rules are revised to clarify the intent of non-covered benefits related to weight loss intervention and treatment including bariatric surgical procedures, other weight loss surgeries and procedures, drugs primarily used for weight loss, and nutrition services prescribed only for the intent of weight loss under the Individual Plan (IP) program. These benefits have never been covered under the IP program; this simply provides the clarification.

Original signed on 8/24/09

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Mary Stalnaker, Director  
Family Support Services Division

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Sandra Harrison, Coordinator  
Office of Legislative Relations and  
Policy

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WF # 09-T (NAP)

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**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.

<b><u>REMOVE</u></b>	<b><u>INSERT</u></b>
317:2-1-1	317:2-1-1, 1 page only, revised 7-21-09
317:2-1-2	317:2-1-2, pages 1-3, revised 7-21-09
317:2-1-6	317:2-1-6, 1 page only, revised 7-21-09
317:2-1-7	317:2-1-7, pages 1-2, revised 7-21-09
317:2-1-8	317:2-1-8, 1 page only, revised 7-21-09
317:2-1-9	317:2-1-9, 1 page only, revised 7-21-09
317:2-1-10	317:2-1-10, pages 1-2, revised 7-21-09
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317:2-1-12	317:2-1-12, pages 1-2, revised 7-21-09
317:2-1-13	317:2-1-13, 1 page only, revised 7-21-09
317:30-3-27	317:30-3-27, pages 1-5, revised 7-21-09
317:30-3-80	-----
317:30-5-1091	317:30-5-1091, 1 page only, revised 7-21-09
317:35-5-25	317:35-5-25, pages 1-10, revised 7-21-09
317:45-11-11	317:45-11-11, pages 1-2, revised 9-1-09



**317:2-1-1. Purpose**

The purpose of this Chapter is to describe the different types of grievances addressed by the Oklahoma Health Care Authority (OHCA). The rules explain the step by step processes that must be followed by a party seeking redress from the OHCA. All hearings on eligibility issues for members are conducted by the Oklahoma Department of Human Services, and are not contained in this Chapter. Hearings will not be granted when the sole issue to be determined is a Federal or State law requiring an automatic change adversely affecting some or all members.



**317:2-1-2. Appeals****(a) Member Process Overview.**

(1) The appeals process allows a member to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to file an appeal, the member files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal.

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received within 30 days of written notice sent by OHCA according to Title 68 O.S. ' 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out and necessary documentation not included, then the appeal will not be heard.

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

(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to OAC 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (Section OAC 317:2-1-13).

(7) Member appeals are ordinarily decided within 90 days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 C.F.R. Section 431.244(f)]

(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within 20 days of the hearing before the ALJ.

**(b) Provider Process Overview.**

(1) The proceedings as described in this Section contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(c)(2).

(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under OAC 317:2-1-2(c)(2).

(A) The Appellant (Appellant is the provider who files a grievance) files an LD form requesting a grievance hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider grievances and LD-3 forms are for nursing home wage enhancement grievances.)

(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

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

(D) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.

(E) The Administrative Law Judge's decision is appealable to OHCA's CEO under OAC 317:2-1-13.

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

(1) Member Appeals:

(A) Discrimination complaints regarding the SoonerCare program;

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

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

(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;

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

(F) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions; and

(2) Provider Appeals:

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

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

- (C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5), (e)(8), and (e)(12);
- (D) Petitions for Rulemaking;
- (E) Appeals of insureds participating in Insure Oklahoma/ O-EPIC which are authorized by OAC 317:45-9-8(a);
- (F) Appeals to the decision made by the Business Contracts manager related to Purchasing as found at OAC 317:10-1-5 and other appeal rights granted by contract;
- (G) Drug rebate appeals;
- (H) Nursing home contracts which are terminated, denied, or non-renewed; and
- (I) Proposed administrative sanction appeals pursuant to OAC 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions.

**317:2-1-6. Other grievance procedures and processes**

Other grievance procedures and processes include those set out in OAC 317:2-1-7 (Program Integrity Audits/Reviews Appeals); OAC 317:2-1-8 (Nursing Home Provider Contract Appeals); OAC 317:2-1-9 (OHCA's Designated Agent's Appeal Process for QIO Services); OAC 317:2-1-10 (Drug Rebate Appeal Process); OAC 317:2-1-11 [Medicaid Drug Utilization Review Board (DUR) Appeal Process]; and OAC 317:2-1-12 (For Cause Provider Contract Suspension/Termination Appeals Process).



**317:2-1-7. Program Integrity**

All Program Integrity Audits/Reviews appeals are made to the State Medicaid Director.

(1) If a provider disagrees with a decision of Program Integrity including statewide surveillance and utilization control program appeals, which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision to the State Medicaid Director.

(2) The appeal from the Program Integrity decision will be commenced by the receipt of a letter from the appellant provider. The letter must set out with specificity, the overpayment decision to which the provider objects along with the grounds for appeal. The letter should explain in detail, the factual and/or legal basis for disagreement with the allegedly erroneous decision. The letter should also include all relevant exhibits the provider believes necessary to decide the appeal.

(3) Upon receipt of the appeal by the docket clerk, the matter will be docketed for the next meeting of the Medical Advisory Committee (MAC). Any appeal received less than four weeks before a scheduled MAC meeting will be set for the following MAC meeting.

(4) The appeal will be forwarded to the OHCA Legal Services Division by the docket clerk for distribution to the members of the subcommittee and for preparation of the OHCA's case. A subcommittee of the MAC will be formed and render a recommendation to the State Medicaid Director.

(5) At the discretion of the MAC, witnesses may be called and information may be solicited from any party by letter, telephonic communication, fax, or other means. The subcommittee may request that members of the OHCA be present during their consideration of the appeal. Members of the OHCA's Legal Division may be asked to answer legal questions regarding the appeal.

(6) The subcommittee will issue a recommendation regarding the appeal, in writing, within 30 days of the hearing. An exception to the 30 day rule will apply in cases where the subcommittee sets the case over until its next scheduled meeting in order to gather additional evidence. The written recommendation will list the members of the subcommittee who participated in the decision. In cases where an appeal must be continued, the subcommittee will issue a letter within 30 days of the initial hearing to inform the appellant of the continuance.

(7) The recommendation, after being formalized, will be sent to the docket clerk for review by the State Medicaid Director. The State Medicaid Director will ordinarily issue a decision

regarding the appeal within 60 days of the docket clerk's receipt of the recommendation from the MAC. The decision will be issued to the appellant or his/her authorized agent.

(8) If the provider is dissatisfied with the Medicaid Director's decision, it may be appealed to the CEO under OAC 317:2-1-13.

**317:2-1-8. Nursing home provider contract appeals**

This Section explains the appeal process to be accorded all nursing home providers whose contracts are terminated, denied or non-renewed. No procedure is afforded a nursing facility whose contract is limited in any other fashion.

(1) If a nursing home provider's contract is terminated, non-renewed or denied prior to the action's effective date, the provider will be afforded an informal reconsideration in accordance with 42 C.F.R. 421.153.

(2) The notice of termination, non-renewal or, denial of contract will include the findings it was based upon. The letter will be sent by certified mail to the provider.

(3) The provider will have 60 days to respond to the notice unless there is a finding of immediate jeopardy or a determination that the facility's SoonerCare certification has been cancelled prior to 60 days. The response should outline the reasons why the OHCA's decision to terminate, non-renew, or deny the contract is wrong. The response by the provider must include a detailed position addressing the findings set out in the OHCA's letter. In the event that less than a 60 day notice is provided for either reason stated above, the provider will be afforded a notice in as much time before decertification as possible.

(4) Based upon the provider's response, the OHCA will affirm or deny the notice of non-renewal, termination or denial.



**317:2-1-9. OHCA's Designated Agent's appeal process for QIO Decisions**

The OHCA's Quality Improvement Organization (QIO) conducts an administrative process for those providers it reviews. The process afforded providers by QIO is the only administrative remedy available to providers. The decision issued by the QIO is considered by the OHCA to be a final administrative determination. The final QIO determination is not appealable to the OHCA for any further administrative hearings. After the QIO'S decision, OHCA will recoup the monies paid the provider related to the review.



**317:2-1-10. Drug Rebate appeal process**

The purpose of this Section is to afford a process to both the manufacturer and the state to administratively resolve drug rebate discrepancies. These rules anticipate discrepancies between the manufacturer and OHCA which would require the manufacturer to pay a higher rebate or a lower rebate. These regulations provide a mechanism for both informal dispute resolution of drug rebate discrepancies between the manufacturer and OHCA and a mechanism for appeals of drug rebate discrepancies between the manufacturer and OHCA.

(1) The process begins at the end of each calendar quarter when the OHCA mails a copy of the State's past quarter's utilization data to the manufacturer. Utilization data and a billing for rebates will be mailed to the manufacturer within 60 days after the end of each quarter. It is this data which dictates the application of the federal drug rebate formula.

(2) Within 30 days from the date utilization data is sent to the manufacturer, the manufacturer may edit state data and resolve data inconsistencies with the state. The manufacturer may utilize telephone conferences, letters and any other mechanism to resolve data inconsistencies in mutual agreement with the state.

(3) Within 30 days after the utilization data is mailed to the manufacturer, the manufacturer may:

(A) pay the same amount as billed by the state with the quarterly utilization date;

(B) pay an amount which differs from the amount billed by the state with the utilization data and send disputed data information;

(C) pay nothing and send no disputed data information;

(D) pay nothing and send disputed data information.

(4) In the event the state receives the rebate amount billed by the 30<sup>th</sup> day, the dispute ends.

(5) If after 30 days one of the following events occurs, the state will acknowledge the receipt of the correspondence and review the disputed data:

(A) the receipt of an amount lower than that billed to the manufacturer;

(B) the receipt of disputed data.

(6) In the event no disputed data is received and no payment is received, interest will be computed in accordance with the provisions of federal law found at 42 U.S.C. Section 1396b(d)(5) and will be compounded upon the amount billed from 38 days after the date utilization data is sent.

(7) In the event a lower amount than billed is paid or in the event disputed data is sent, and no money is received, interest

will be computed in accordance with 42 U.S.C. Section 1396b(d)(5) and will be computed from 38 days from the date utilization data is sent to the manufacturer.

(8) Within 70 days from the date utilization data is sent to the manufacturer, the state will make its final informal review of the disputed data. OHCA will mail a second notice to the manufacturer which will include:

- (A) receipt of the rebate, if any;
- (B) receipt of the dispute;
- (C) a statement regarding the interest amount; and
- (D) a statement regarding the appeal rights of the manufacturer with a copy of the appeal form.

(9) Within 90 days of the date utilization data is sent to the manufacturer or within 20 days of the date a second notice is mailed to the manufacturer, whichever is sooner, the state or the manufacturer may request a hearing to administratively resolve the matter.

(10) The administrative appeal of drug rebate discrepancies includes:

(A) The appeal process will begin by the filing of a form LD-2 by the manufacturer or OHCA.

(B) The process afforded the parties will be the process found at OAC 317:2-1-2(b) and (c).

(C) With respect to the computation of interest, interest will continue to be computed from the 38 day based upon the policy contained in the informal dispute resolution rules above.

(D) The ALJ's decision will constitute the final administrative decision of the OHCA.

(E) If the decision of the ALJ affirms the decision of OHCA in whole or in part, payment from the manufacturer must be made within 30 days of the decision. If the decision of the ALJ reverses the decision of the OHCA, the OHCA will make such credit or action within 30 days of the decision of the ALJ.

(F) The nonpayment of the rebate by the manufacturer within 30 days after the ALJ's decision will be reported to the Centers for Medicare and Medicaid Services and may be the basis of an exclusion action by the OHCA.

**317:2-1-11. Medicaid Drug Utilization Review Board (DUR) appeal process**

This Section explains the appeal process, pursuant to 63 O.S. '5030.3(B)(Supp. 1999), accorded any party aggrieved by a decision of the OHCA Board or Administrator (CEO) concerning a proposed recommendation of the Medicaid Drug Utilization Review Board (DUR).

(1) The aggrieved party may appeal pursuant to OAC 317:2-1-2 et seq. (OHCA Appeals).

(2) The Board finds that the prescription of Title 63 O.S. '5030.3(B) is somewhat contradictory with the functions of the DUR Board. More specifically, in most instances, the DUR Board suggests policies that must be rule made. Rules promulgated by the OHCA Board do not lend to an "individual proceeding notice" as contemplated by Article II of the Oklahoma Administrative Procedures Act, specifically, Title 75 O.S. '309. Thus, in instances where the OHCA Board promulgates rules as a result of policy recommendations by the DUR Board, this Board will consider a party aggrieved by these rules to have filed a Petition for Rulemaking under 75 O.S. '305. In making this interpretation of 63 O.S. '5030.1, the Board will not enforce the last sentence of 75 O.S. '305. In making this interpretation, the Board finds that it is taking two somewhat conflicting provisions, and combining them to effectuate the intent of the legislature - to provide a hearing to those aggrieved by recommendations by the DUR Board and accepted by the OHCA Board.

(3) In instances where the DUR Board makes a recommendation accepted by the Board against an individual provider [for example, a recommendation under 42 U.S.C. 1396r-8(g)(3)(C)(iii)(IV)], OHCA will provide an individual proceeding under the Oklahoma Administrative Procedures Act.

(4) In any appeal under (1) and (2) of this subsection, the OHCA Board delegates the OHCA ALJ to preside over the above hearing and present the Board with proposed findings of fact and conclusions of law in accordance with Article II of the Administrative Procedures Act. The OHCA Board may accept the ALJ's written decision, reject it, or amend the recommendations.

(5) Appeals filed pursuant to (1) and (2) of this subsection, will be made within 20 days of the OHCA Board's acceptance of the recommendation by the DUR Board.

(6) After Proposed Findings of Fact and Conclusions of Law are presented to the OHCA Board, the Board will have a period of 120 days to issue a final administrative order.

(7) The Agency's Legal Services Division will construct a form called the LD-3, which will be used for parties to file an

action under (1) and (2) of this subsection.

**317:2-1-12 For Cause provider contract suspension/termination appeals process**

This Section explains the appeals process for providers whose SoonerCare contracts have been suspended/terminated by the OHCA for cause. Those providers whose contracts have been affected by other OHCA actions cannot request an appeal of those measures. Contracts terminated or suspended for cause are either timed terminations (30, 60, or 90 day) or immediate terminations/suspensions. Paragraphs (1) and (2) apply to timed terminations/suspensions and paragraph (3) applies to immediate terminations.

**(1) Procedure for suspending/terminating provider's contract.**

**(A) Notice of proposed suspension or termination.** The OHCA will provide notice to the medical services provider of the proposed suspension or termination of provider contract. The written notice of suspension/termination will state:

- (i) the reasons for the proposed suspension/termination;
- (ii) the date upon which the suspension/termination will be effective; and
- (iii) a statement that the medical services provider has a right to review prior to the suspension/termination of the provider's contract (refer to subparagraph (B) of this paragraph).

**(B) Right to review prior to suspension/termination of provider contract.** Before the medical services provider's contract is suspended or terminated, the OHCA will give the medical services provider the opportunity to submit documents and written arguments against the suspension/termination of the provider's contract.

**(C) Notice of suspension or termination.**

(i) After the review of the medical services provider's written response, the OHCA will make a final administrative decision subject to a post-suspension or termination hearing.

(ii) After the review of the medical services provider's written response, the OHCA will make a final administrative decision subject to a post-sanction hearing. Should the OHCA decide not to suspend or terminate the provider's contract, the medical services provider will be notified of the reasons for the decision.

(iii) Should the OHCA make a decision to suspend or terminate the medical services provider's contract, the OHCA will send a notice stating:

- (I) the reasons for the decision;
- (II) the effective date of the suspension or termination of the contract;

(III) the medical services provider's right to request a post-suspension or termination hearing; and

(IV) the requirements and procedures for reinstatement.

(2) **Post-suspension/termination hearing.** After the effective date of the suspension or termination of the provider's contract, the medical services provider is entitled to receive a post-suspension or termination hearing. The hearing committee for the OHCA will be comprised of three members of the OHCA and two other members as appointed. The representative who investigated the case will not be a representative if an investigation was initiated or completed.

(A) After the provider's request for the post-suspension/termination hearing is made, a hearing date will be established. A certified letter will be sent to the provider giving notification of the hearing date and naming the contact person. The contact person will answer procedural questions about the hearing.

(B) Ten days prior to the hearing, the medical services provider will submit a brief written statement detailing the evidence which will be presented by the provider at the hearing. Such statement must detail the facts which will be refuted by the provider. The purpose of the hearing will be limited to issues raised in the letter of suspension or termination as the cause of suspending or terminating the provider contract.

(C) The provider may be represented by an authorized representative, with documentation to that effect, at the informal hearing and/or the provider may present testimony himself or herself and have witnesses present.

(D) At the conclusion of the hearing, a decision will be made by the Hearing Committee. The provider will be notified in writing of the decision within 20 days of the final day of the hearing. The decision letter will constitute the agency's final decision regarding the matter.

(3) **Notice of immediate suspension or termination.** The process below will be followed in the event of an immediate suspension or termination:

(A) A notice described in paragraph (1)(A) will be sent to the provider, except there is no right to review prior to an immediate termination or suspension.

(B) A post suspension termination review will be conducted in accordance with paragraph (2) above.

**317:2-1-13. Appeal to the Chief Executive Officer**

An appeal to the Chief Executive Officer (CEO) of the Oklahoma Health Care Authority includes:

(1) Within 20 days of decisions made pursuant to provider or Program Integrity Audits/Reviews appeals found at this Chapter, either party may appeal a decision to the CEO of the OHCA. Such appeal will be commenced by a letter or fax received by the CEO within 20 days of the receipt of the prior decision made by the ALJ or Medicaid Director. The appeal will concisely and fully explain the reasons for the request. No new evidence may be presented to the CEO. Evidence presented must be confined to the records below.

(2) Appeals to the CEO under member proceedings will be commenced by a letter received no later than 10 days of the receipt of the decision by the ALJ. Should the appellant request a transcription to prosecute its appeal to the CEO, the appellant will be required to execute a waiver relieving the OHCA from completing its fair process hearing within 90 days.

(3) For provider and Program Integrity Audits/Reviews proceedings, the CEO will ordinarily have 90 days from receipt of the appeal to render a written decision.

(4) For member proceedings, the CEO will ordinarily have 30 days from receipt of the appeal to render a written decision.

(5) The only appeal for proposed provider or member administrative sanctions is before the ALJ and the ALJ decision is not appealable to the CEO.



**317:30-3-27. Telemedicine**

(a) **Applicability and scope.** The purpose of this Section is to implement telemedicine policy that improves access to health care services by enabling the provision of medical specialty care in rural or underserved areas to meet the needs of members and providers alike, while complying with all applicable federal and state statutes and regulations. Telemedicine services are not an expansion of SoonerCare covered services but an option for the delivery of certain covered services. SoonerCare views telemedicine no differently than an office visit or outpatient consultation. However, if there are technological difficulties in performing an objective through medical assessment or problems in member's understanding of telemedicine, hands-on-assessment and/or care must be provided for the member. Quality of health care must be maintained regardless of the mode of delivery.

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

(1) **"Certified or licensed health care professional"** means an individual who has successfully completed a prescribed program of study in any variety of health fields and who has obtained an Oklahoma state license or certificate indicating his or her competence to practice in that field.

(2) **"Distant site"** means the site where the specialty physician/practitioner providing the professional service is located at the time the service is provided via audio/video telecommunications.

(3) **"Interactive telecommunications"** means multimedia communications equipment that includes, at a minimum, audio/video equipment permitting two-way, real-time or near real-time service or consultation between the member and the practitioner.

(4) **"Originating site"** means the location of the SoonerCare member at the time the service is being performed by a contracted provider via audio/video telecommunications.

(5) **"Rural area"** means a county with a population of less than 50,000 people.

(6) **"Store and forward"** means the asynchronous transmission of medical information to be reviewed at a later time. A camera or similar device records (stores) an image(s) that is then sent (forwarded) via telecommunications media to another location for later viewing. The sending of x-rays, computed tomography scans, or magnetic resonance images are common store and forward applications. The original image may be recorded and/or forwarded in digital or analog format and may include video

"clips" such as ultrasound examinations, where the series of images that are sent may show full motion when reviewed at the receiving location.

(7) **"Telehealth"** means the use of telecommunication technologies for clinical care (telemedicine), patient teaching and home health, health professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system.

(8) **"Telemedicine"** means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the real-time or near real-time and in the physical presence of the member.

(9) **"Telemedicine network"** means a network infrastructure, consisting of computer systems, software and communications equipment to support telemedicine services.

(10) **"Underserved area"** means an area that meets the definition of a medically underserved area (MUA) or medically underserved population (MUP) by the U.S. Department of Health and Human Services (HHS).

(c) **Coverage.** SoonerCare coverage for telemedicine technology is limited to consultations, office visits, individual psychotherapy, psychiatric diagnostic interview examinations and testing, mental health assessments and pharmacologic management.

(1) An interactive telecommunications system is required as a condition of coverage.

(2) Coverage for telemedicine services is limited to members in rural areas, underserved areas, or geographic areas where there is a lack of medical/psychiatric/mental health expertise locally.

(3) Office and outpatient visits that are conducted via telemedicine are counted toward the applicable benefit limits for these services.

(4) Authorized originating sites are:

(A) The office of a physician or practitioner;

(B) A hospital;

(C) A school;

(D) An outpatient behavioral health clinic;

(E) A critical access hospital;

(F) A rural health clinic (RHC);

(G) A federally qualified health center (FQHC); or

(H) An Indian Health Service facility, a Tribal health facility or an Urban Indian clinic (I/T/U).

(5) Authorized distant site specialty providers are contracted:

(A) Physicians;

- (B) Advanced Registered Nurse Practitioners;
- (C) Physicians Assistants;
- (D) Genetic Counselors;
- (E) Licensed Behavioral Health Professionals;
- (F) Dieticians; and
- (G) I/T/U's with specialty service providers as listed in (A) through (F) above.

(d) **Non-covered services.** Non-covered services include:

- (1) Telephone conversation;
- (2) Electronic mail message; and
- (3) Facsimile.

(e) **Store and forward technology.** SoonerCare covers store and forward technology for applications in which, under conventional health care delivery, the medical service does not require face-to-face contact between the member and the provider. Examples include teleradiology, telepathology, fetal monitor strips, as well as physician interpretation of electrocardiogram and electroencephalogram readings that are transmitted electronically. SoonerCare does not consider these services telemedicine as defined by OHCA and will not reimburse an originating site fee for these services.

(f) **Conditions.** The following conditions apply to all services rendered via telemedicine.

- (1) Interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the SoonerCare member. As a condition of payment the member must be present and participating in the telemedicine visit.
- (2) Only telemedicine services provided utilizing an OHCA approved network are eligible for reimbursement.
- (3) For SoonerCare reimbursement, telemedicine connections to rural areas must be located within Oklahoma and the health providers must be licensed in Oklahoma or practice at an I/T/U.
- (4) The telemedicine equipment and transmission speed must be technically sufficient to support the service billed. If a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality for decision making. Staff involved in the telemedicine visit need to be trained in the use of the telemedicine equipment and competent in its operation.
- (5) An appropriate certified or licensed health care professional at the originating site is required to present the member to the physician or practitioner at the distant site and remain available as clinically appropriate.

(6) The health care practitioner must obtain written consent from the SoonerCare member that states they agree to participate in the telemedicine-based office visit. The consent form must include a description of the risks, benefits and consequences of telemedicine and be included in the member's medical record.

(7) If the member is a minor child, a parent/guardian must present the minor child for telemedicine services unless otherwise exempted by State or Federal law. The parent/guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.

(8) The member retains the right to withdraw at any time.

(9) All existing confidentiality protections apply.

(10) The member has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.

(11) There will be no dissemination of any member images or information to other entities without written consent from the member.

(g) **Reimbursement.**

(1) A facility fee will be paid to the originating site when the appropriate telemedicine facility fee code is used.

(A) Hospital outpatient: When the originating site is a hospital outpatient department, payment for the originating site facility fee will be paid according to the SoonerCare fee schedule.

(B) Hospital inpatient: For hospital inpatients, payment for the originating site facility fee will be paid outside the Diagnostic Related Group (DRG) payment.

(C) FQHCs and RHCs: The originating site facility fee for telemedicine services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee is paid separately from the center or clinic all-inclusive rate.

(D) Facilities of the Indian Health Service, tribal facilities or Urban Indian Clinics: When an I/T/U serves as the originating site, the originating site facility fee is reimbursed outside the OMB rate.

(E) Physicians'/practitioners' offices: When the originating site is a physician's office, the originating site facility fee will be paid according to the SoonerCare fee schedule. If a provider from the originating site performs a separately identifiable service for the member on the same day as telemedicine, documentation for both services must be clearly and separately identified in the member's medical record.

(2) Services provided by telemedicine must be billed with the appropriate modifier. Only the portion of the telemedicine

service rendered from the distant site is billed with the modifier.

(3) If the technical component of an X-ray, ultrasound or electrocardiogram is performed at the originating site during a telemedicine transmission, the technical component and a telemedicine facility fee are billed by the originating site. The professional component of the procedure and the appropriate visit code are billed by the distant site.

(4) Post payment review may result in adjustments to payment when a telemedicine modifier is billed inappropriately or not billed when appropriate.

(5) The cost of telemedicine equipment and transmission is not reimbursable by SoonerCare.

**(h) Documentation.**

(1) Documentation must be maintained at the originating and the distant locations to substantiate the services provided.

(2) Documentation must indicate the services were rendered via telemedicine, the location of the originating and distant sites, and which OHCA approved network was used.

(3) All other SoonerCare documentation guidelines apply to the services rendered via telemedicine. Examples include but are not limited to:

(A) Chart notes;

(B) Start and stop times;

(C) Service provider's credentials; and

(D) Provider's signature.

**(i) Telemedicine network standards.** In order to be an approved telemedicine network, an applicant must be contracted with the OHCA and meet certain technical and privacy standards stated within the contract in order to ensure the highest quality of care.



**317:30-5-1091. Definition of I/T/U services**

(a) As described in Title 42 of the Code of Federal Regulations (CFR) 136.11(a), the I/T/U services may include hospital and medical care, dental care, public health nursing and preventive care (including immunizations), and health examination of special groups such as school children.

(b) Further, Title 42 CFR 136.11(c) allows that the scope and availability of I/T/U services will depend upon the resources of the facility.

(c) I/T/U services may be covered when furnished to a patient at the clinic or other location, including a mobile clinic, or the patient's place of residence.

(d) I/T/U outpatient encounters include but are not limited to:

(1) Physicians' services and supplies incidental to a physician's services;

(2) Within limitations as to the specific services furnished, a doctor of dentistry or oral surgery, a doctor of optometry, or a doctor of podiatry [Refer to Section 1861(r) of the Act for specific limitations];

(3) The services of a resident as defined in OAC 317:25-7-5(4) who meets the requirements for payment under SoonerCare and the supplies incidental to a resident's services;

(4) Services of advanced practice nurses (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;

(5) Services and supplies incidental to the services of APNs and PAs (including services furnished by certified nurse midwives);

(6) Public health nursing services include but are not limited to services in the following areas:

(A) Phlebotomy;

(B) Wound care;

(C) Public health education;

(D) Administration of immunizations;

(E) Administration of medication;

(F) Child health screenings meeting EPSDT criteria;

(G) Prenatal, newborn and postpartum assessments, including case management services for first time mothers; and

(H) General health assessments and management of conditions such as tuberculosis, diabetes and hypertension.

(7) Visiting nurse services to the homebound;

(8) Behavioral health professional services and services and supplies incidental to the services of LBHPs; and

(9) Dental services.



**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.

(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 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.

**317:45-11-11. INSURE OKLAHOMA/O-EPIC IP non-covered services**

Certain health care services are not covered in the Insure Oklahoma/O-EPIC IP benefit package listed in OAC 317:45-11-10. These services include, but are not limited to:

- (1) services that the member's PCP or Insure Oklahoma/O-EPIC does not consider medically necessary;
- (2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
- (3) organ and tissue transplant services;
- (4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;
- (5) procedures, services and supplies related to sex transformation;
- (6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
- (7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
- (8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
- (9) experimental procedures, drugs or treatments;
- (10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) except for pregnant women and as covered in OAC 317:30-5-696;
- (11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
- (12) physical medicine including chiropractic, acupuncture and osteopathic manipulation therapy;
- (13) hearing services;
- (14) transportation [emergent or non-emergent (air or ground)];
- (15) rehabilitation (inpatient);
- (16) cardiac rehabilitation;
- (17) allergy testing and treatment;
- (18) home health care with the exception of medications, intravenous (IV) therapy, supplies;
- (19) hospice regardless of location;
- (20) Temporomandibular Joint Dysfunction (TMD) (TMJ);
- (21) genetic counseling;
- (22) fertility evaluation/treatment/and services;
- (23) sterilization reversal;
- (24) Christian Science Nurse;
- (25) Christian Science Practitioner;

- (26) skilled nursing facility;
- (27) long-term care;
- (28) stand by services;
- (29) thermograms;
- (30) abortions (for exceptions, refer to OAC 317:30-5-6);
- (31) services of a Lactation Consultant;
- (32) services of a Maternal and Infant Health Licensed Clinical Social Worker; and
- (33) enhanced services for medically high risk pregnancies as found in OAC 317:30-5-22.1.