
POLICY TRANSMITTAL NO. 08-41	DATE: AUGUST 20, 2008
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS AND POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-3-6; 30-3-12; 30-3-23; 30-5-8; 30-5-65; 30-5-126;
30-5-131.2; 30-5-132; 30-5-133.2; 30-5-134; and 30-5-245.

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

Agency rules are revised to update the agency's designated agent that reviews the length of stay and appropriateness of hospital admissions from the "Oklahoma Foundation for Medical Quality" to the generic term, "Quality Improvement Organization" since the agency no longer contracts with the OFMQ. Revisions are also made to remove an invalid billing and inquiry reference and replace it with a valid reference.

Surgery rules are revised to remove modifiers and refer physicians to the Healthcare Common Procedure Coding System (HCPCS) for procedure and diagnosis coding guidance. Opportunities for Living Life rules are revised to make them consistent with nursing home policy found in the Durable Medical Equipment section of policy by removing the prior authorization requirement for oxygen concentrators and supplies, liquid oxygen systems, and portable oxygen and supplies.

Long Term Care Facility rules are revised to: (1) remove outdated information regarding payment to the nursing facility when the member is in the hospital; (2) add language to freeze the Quality of Care Fee at levels in effect July 1, 2004, and implement 5.5% as a maximum, as per federal law; (3) add language to include additional items needed in the Quality of Care Report in order to implement the Focus on Excellence Program; (4) update language to add the requirement regarding the filing of cost reports on the Secure Website and to change the due date from September 1st to October 31st; (5) define the cost report requirement for partial year reports; and (6) delete obsolete language.

Rules are revised to remove current outpatient behavioral health reimbursement language and replace it with language found in the Medicaid state plan. This makes the behavioral health reimbursement section consistent with other reimbursement sections in rules.

Original signed on 8-19-08

Mary Stalnaker, Director
Family Support Services Division

Sharon Neuwald, Coordinator
Office of Legislative Relations and Policy

WF # 08-Q (NAP)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

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

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

REMOVE

317:30-3-6

317:30-3-12

317:30-3-23

317:30-5-8

317:30-5-65

3117:30-5-126

317:30-5-131.2

317:30-5-132

317:30-5-133.2

317:30-5-134

317:30-5-245

INSERT

317:30-3-6, 1 page only, revised 7-25-08

317:30-3-12, 1 page only, revised 7-25-08

317:30-3-23, 1 page only, revised 7-25-08

317:30-5-8, 1 page only, revised 7-25-08

317:30-5-65, 1 page only, revised 7-25-08

317:30-5-126, 1 page only, revised 7-25-08

317:30-5-131.2, pages 1-7, revised 7-25-08

317:30-5-132, pages 1-2, revised 7-25-08

317:30-5-133.2, 1 page only, revised 7-25-08

317:30-5-134, pages 1-2, revised 7-25-08

317:30-5-245, 1 page only, revised 7-25-08

317:30-3-6. Utilization review for physician/hospital services

The Surveillance and Utilization Review System (SURS) is used to help identify patterns of inappropriate care and services.

(1) Use of this system enables OHCA to develop a comprehensive profile of any aberrant pattern of practice and reveals suspected instances of fraud or abuse in the SoonerCare Program.

Also, the Utilization Review program is a useful tool in detecting the existence of any potential defects in the level of care or service provided under the SoonerCare Program.

(2) OHCA contracts with a Quality Improvement Organization (QIO) to review the length of stay and appropriateness of hospital admissions. Unresolved patterns of non-compliance with medical criteria for admissions, outpatient procedures and length of stay will be referred to OHCA.

317:30-3-12. Credits and adjustments

When an overpayment has occurred, the provider should immediately refund the Oklahoma Health Care Authority, by check, to the attention of the Finance Division, P.O. Box 18299, Oklahoma City, OK 73154. In refunding OHCA, be sure to clearly identify the account to which the money is to be applied. The MMIS system has the capability of automatic credits and debits. When an erroneous payment occurs, which results in an overpayment, an automatic recoupment will be made to the provider's account against monies owed to the provider. For more specific information, refer to the Oklahoma Medicaid Provider Billing Manual, Chapter 9: Paid Claim Adjustment Procedures.

317:30-3-23. Reconsideration request

If the QIO, upon their initial review determines the admission should be denied, a notice is issued to the facility and the attending physician advising them of the decision and advising them that a reconsideration request may be submitted in accordance with the Medicare time frame. Additional information submitted with the reconsideration request will be reviewed by the QIO who utilizes an independent physician advisor. If the denial decision is upheld through this reconsideration review of additional information, OHCA is informed. At that point OHCA sends a letter to the hospital and physician requesting a refund of the SoonerCare payment previously made on the denied admission. The member is not responsible for denied charges.

317:30-5-8. Surgery

(a) The OHCA uses certain nationally recognized coding and editing guidelines for determination of reimbursement logic related to situations including, but not limited to, multiple, bilateral, assistant surgery, incidental, and mutually exclusive procedure codes. When a procedure is performed for which specific procedure codes exist, the specific procedure code must be used. A claim submitted with an "unlisted" procedure code is subject to medical review and requires the submission of all pertinent medical records for determination of payment.

(b) The Physicians' Current Procedural Terminology (CPT) provides for 2-digit modifiers to further describe surgical services. These modifiers must be used on OHCA claims when applicable.

(c) Reduction mammoplasty is covered only when the procedure has been determined medically necessary; prior authorization is required.

(d) Intradermal introduction of pigments or tattooing is compensable when related to breast reconstruction; prior authorization is required.

317:30-5-65. Ancillary services

Ancillary services are those items which are not considered routine services. Ancillary services may be billed separately to the SoonerCare program, unless reimbursement is available from Medicare or other insurance or benefit programs. Coverage criteria, utilization controls and program limitations are specified in Part 17 of OAC 317:30-5. Ancillary services are limited to the following services:

- (1) Services requiring prior authorization:
 - (A) Ventilators and supplies.
 - (B) Total Parenteral Nutrition (TPN), and supplies.
 - (C) Custom wheelchairs.
 - (D) Enteral feeding.
- (2) Services not requiring prior authorization:
 - (A) Permanent indwelling or male external catheters and catheter accessories.
 - (B) Colostomy and urostomy supplies.
 - (C) Tracheostomy supplies.
 - (D) Prescription drugs, laboratory procedures, and x-rays.

317:30-5-126. Therapeutic leave and Hospital leave

Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made.

(1) Effective July 1, 1994, the nursing facility may receive payment for a maximum of seven (7) days of therapeutic leave per calendar year for each recipient to reserve the bed. Claims for therapeutic leave are to be submitted on Form Adm-41 (Long Term Care Claim Form).

(2) Effective January 1, 1996, the nursing facility may receive payment for a maximum of five days of hospital leave per calendar year for each recipient to reserve the bed when the patient is admitted to a licensed hospital.

(3) The Intermediate Care Facility for the Mentally Retarded (ICF/MR) may receive payment for a maximum of 60 days of therapeutic leave per calendar year for each recipient to reserve a bed. No more than 14 consecutive days of therapeutic leave may be claimed per absence. Recipients approved for ICF/MR on or after July 1 of the year will only be eligible for 30 days of therapeutic leave during the remainder of that year. Claims for therapeutic leave are to be submitted on Form Adm-41.

(4) Midnight is the time used to determine whether a patient is present or absent from the facility. The day of discharge for therapeutic leave is counted as the first day of leave, but the day of return from such leave is not counted. For hospital leave, the day of hospital admission is the first day of leave. The day the patient is discharged from the hospital is not counted as a leave day.

(5) Therapeutic and hospital leave balances are recorded on the Medicaid Management Information System (MMIS) recipient record based on the Form Adm-41 submitted by the facility. When a patient moves to another facility, it is the responsibility of the transferring facility to forward the patient's leave records to the receiving facility. Forms are available in the local county OKDHS office.

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

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

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

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

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

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

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

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

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

(8) **"Direct-Care Staff"** means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for the mentally retarded pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.

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

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

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

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

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

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

(b) Quality of care fund assessments.

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

(2) In determination of the fee for the time period beginning October 1, 2000, a survey was mailed to each licensed nursing facility requesting calendar year 1999 Total Patient Days, Gross Revenues and Contractual Allowances and Discounts. This data is used to determine the amount of the fee to be assessed for the period of 10-01-00 through 06-30-01. The fee is determined by totaling the "annualized" gross revenue and dividing by the "annualized" total days of service. "Annualized" means that the surveys received that do not cover the whole year of 1999 are divided by the total number of days that are covered and multiplied by 365.

(3) The fee for subsequent State Fiscal Years is determined by using the monthly gross receipts and census reports for the six month period October 1 through March 31 of the prior fiscal year, annualizing those figures, and then determining the fee as defined above. As per 56 O.S. Section 202, as amended, the fees are frozen at the amount in effect at July 1, 2004. Also, the fee will be monitored to never surpass the federal maximum of

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5.5%.

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

(5) The method of collection is as follows:

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

(B) Payment is due to the Oklahoma Health Care Authority by the 15th of the following month. Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of 10% of the amount and interest of 1.25% per month. The Quality of Care Fee must be submitted no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m. (Central Standard Time) of the following business day (Monday-Friday).

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

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

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

Statutes.

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

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

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

- (A) Registered Nurse
- (B) Licensed Practical Nurse
- (C) Nurse Aide
- (D) Certified Medication Aide
- (E) Qualified Mental Retardation Professional (ICFs/MR only)
- (F) Physical Therapist
- (G) Occupational Therapist
- (H) Respiratory Therapist
- (I) Speech Therapist
- (J) Therapy Aide/Assistant
- (K) Social Services Director/Social Worker
- (L) Other Social Services Staff
- (M) Activities Director
- (N) Other Activities Staff
- (O) Combined Social Services/Activities

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

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

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

(d) **Quality of care minimum wage for specified staff.** Effective November 1, 2000, all nursing facilities and private intermediate care facilities for the mentally retarded receiving Medicaid

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payments, in addition to other federal and state regulations, must pay specified staff not less than in the amount of \$6.65 per hour.

Employee positions included for purposes of minimum wage for specified staff are as follows:

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

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

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

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

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, "*Whoever... (2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefit or payment... shall (i) in the case of such statement, representation, concealment, failure, or conversion by any person in connection with furnishing (by that person) of items or services for which payment is or may be made under this title (42 U.S.C. '1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction*

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thereof fined not more than \$10,000 or imprisoned for not more than one year, or both."

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

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

(6) Facilities must submit the monthly report either through electronic mail to the Opportunities for Living Life Division, Long Term Care Quality Initiatives Unit or send the monthly report in disk or paper format by certified mail and pursuant to subsection (e)(14) of this section. The submission date is determined by the date and time recorded through electronic mail or the postmark date and the date recorded on the certified mail receipt.

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

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

(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information

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includes, but is not limited to: staffing ratios; peak in-house resident count; staff hours worked by shift; total patient days; available bed days; Medicare bed days; Medicaid bed days; and total gross receipts.

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

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

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

(13) Under OAC 317:2-1-2, Long Term Care facility providers may appeal the administrative penalty described in (b)(5)(B) and (e)(8) and (e)(12) of this section.

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

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OAC 317:30-5-132 p(1)

317:30-5-132. Cost reports

Each Medicaid-participating long term care facility is required to submit an annual uniform cost report, designed by OHCA, for the state fiscal year just completed. The state fiscal year is July 1 through June 30. The reports must be submitted to the OHCA on or before the last day of October of the subsequent year.

(1) The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions.

(2) The cost report must be filed using the Secure Website. The instructions and data entry screen simulations will be made available on the OHCA public website under the Provider/Long Term Care Facility/Cost Reporting options.

(3) When there is a change of operation or ownership, the selling or closing ownership is required to file a cost report for that portion of the fiscal year it was in operation. The successor ownership is correspondingly required to file a cost report for that portion of the fiscal year it was in operation.

These "Partial Year Reports" must be filed on paper or electronically by e-mail (not on the secure website system) to the Finance Division of the OHCA on the forms and by the instructions found on the OHCA public website (see directions as noted above).

(4) Cost report instructions are mailed annually to each facility before the first of July and are available on the public website.

(5) Normally, all ordinary and necessary expenses net of any offsets of credits incurred in the conduct of an economical and efficiently operated business are recognized as allowable. Allowable costs include all items of Medicaid-covered expense which nursing facilities incur in the provision of routine services. "Routine services" include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, dental examinations, dentures and related services, eye glasses, routine eye examinations, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. (The guidelines for allowable costs in the Medicare program are set forth in the

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Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.)
Ancillary items reimbursed outside the nursing facility rate are
not included in the cost report and are not allowable costs.
(6) All reports are subject to on-site audits and are deemed
public records.

317:30-5-133.2. Ancillary services

(a) Ancillary services are those items which are not considered routine services. Ancillary services may be billed separately to the SoonerCare program, unless reimbursement is available from Medicare or other insurance or benefit programs. Coverage criteria, utilization controls and program limitations are specified in Part 17 of OAC 317:30-5. Ancillary services are limited to the following services:

(1) Services requiring prior authorization:

(A) External breast prosthesis and support accessories.

(B) Ventilators and supplies.

(C) Total Parenteral Nutrition (TPN), and supplies.

(D) Custom seating for wheelchairs.

(2) Services not requiring prior authorization:

(A) Permanent indwelling or male external catheters and catheter accessories.

(B) Colostomy and urostomy supplies.

(C) Tracheostomy supplies.

(D) Catheters and catheter accessories.

(E) Oxygen and oxygen concentrators.

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

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

(b) Items not considered ancillary, but considered routine and covered as part of the routine rate include but are not limited to:

(1) Diapers.

(2) Underpads.

(3) Medicine cups.

(4) Eating utensils.

(5) Personal comfort items.

317:30-5-134. Nurse Aide Training Reimbursement

(a) Nurse Aide training programs and competency evaluation programs occur in two settings, a nursing facility setting and private training courses. Private training includes, but is not limited to, certified training offered at vocational technical institutions. This rule outlines payment for training in either setting.

(b) In the case a nursing facility provides training and competency evaluation in a program that is not properly certified under federal law, the Oklahoma Health Care Authority may offset the nursing facility's payment for monies paid to the facility for these programs. Such action shall occur after notification to the facility of the period of non-certification and the amount of the payment by the Oklahoma Health Care Authority.

(c) In the case of nurse aide training provided in private training courses, reimbursement is made to nurse aides who have paid a reasonable fee for training in a certified training program at the time training was received. The federal regulations prescribe applicable rules regarding certification of the program and certification occurs as a result of certification by the State Survey Agency. For nurse aides to receive reimbursement for private training courses, all of the following requirements must be met:

- (1) the training and competency evaluation program must be certified at the time the training occurred;
- (2) the nurse aide has paid for training;
- (3) a reasonable fee was paid for training (however, reimbursement will not exceed the maximum amount set by the Oklahoma Health Care Authority);
- (4) the Oklahoma Health Care Authority is billed by the nurse aide receiving the training within 12 months of the completion of the training;
- (5) the nurse aide has passed her or his competency evaluation; and
- (6) the nurse aide is employed at a SoonerCare contracted nursing facility as a nurse aide during all or part of the year after completion of the training and competency evaluation.

(d) If all the conditions in subsection (c) are met, then the Authority will compensate the nurse aide based upon the following pro-rata formula:

- (1) For every month employed in a nursing facility, OHCA will pay 1/12 of the sum of eligible expenses incurred by the nurse aide. The term "every month" is defined as a period of 16 days or more within one month.
- (2) The maximum amount paid by the Oklahoma Health Care

Authority may be set by the Rates and Standards Committee. The rate paid by the nurse aide, up to the maximum set by the Oklahoma Health Care Authority, will be paid in the event a nurse aide was employed all 12 months after completion of the training program.

(e) The claimant must submit a completed Nurse Aide Training Reimbursement Program Form and ADM-12 claim voucher. Documentation of eligible expenses must also be provided. Eligible expenses include course training fees, textbooks and exam fees.

(f) No nurse aide trained in a nursing facility program that has an offer of employment or is employed by the nursing facility in any capacity at the inception of the training program may be charged for the costs associated with the nurse aide training or competency evaluation program.

(g) The SoonerCare share of Nurse Aide training and testing costs incurred by a nursing facility will be reimbursed in the following manner:

(1) Quarterly, the facilities incurring expense and requesting reimbursement for the Medicaid share of Nurse Aide Training costs will complete and file a "Nurse Aide Training and Testing Costs" report as prescribed by the OHCA. These reports will be due by the end of the subsequent month.

(2) From the "Nurse Aide Training and Testing Costs" reports the OHCA will determine a cost per day for each facility for the period.

(3) The OHCA will pay each facility based on the reported cost per day applied to the actual SoonerCare paid days that matches the period reported by the facility.

(4) Nurse Aide Training Costs are not allowable for cost reporting purposes.

**MEDICAL PROVIDERS-FEE FOR SERVICE
OUTPATIENT BEHAVIORAL HEALTH
SERVICES SPECIFIC**

OAC 317:30-5-245

317:30-5-245. Reimbursement

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