
POLICY TRANSMITTAL NO. 07-51	DATE: AUGUST 27, 2007
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 317:30-5-133.1; 30-5-326 through 30-5-327.9; 30-5-1076; and 35-3-2.

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

Rules for SoonerCare transportation and subsistence are revised to define members eligible for non-emergency transportation (NET) and the availability and access for utilization of the SoonerRide program for all NET qualified members. Rules are reorganized to be more user friendly for providers and members by adding definitions and grouping like services together.

Nutrition Services rules are revised to increase the maximum hours of medically necessary nutritional counseling by a licensed registered dietician to six hours per year.

Original signed on 8-24-07

Mary Stalnaker, Director
Family Support Services Division

Sharon Neuwald, Coordinator
Office of Legislative Relations and Policy

WF # 07-W (NAP)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

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

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

<u>REMOVE</u>	<u>INSERT</u>
317:30-5-133.1	317:30-5-133.1, pages 1-5, revised 6-25-07
-----	317:30-5-326, 1 page only, issued 6-25-07
-----	317:30-5-326.1, 1 page only, issued 6-25-07
317:30-5-327	317:30-5-327, 1 page only, revised 6-25-07
-----	317:30-5-327.1, 1 page only, issued 6-25-07
-----	317:30-5-327.2, 1 page only, issued 6-25-07
-----	317:30-5-327.3, pages 1-2, issued 6-25-07
-----	317:30-5-327.4, 1 page only, issued 6-25-07
-----	317:30-5-327.5, 1 page only, issued 6-25-07
-----	317:30-5-327.6, 1 page only, issued 6-25-07
-----	317:30-5-327.7, 1 page only, issued 6-25-07
-----	317:30-5-327.8, 1 page only, issued 6-25-07
-----	317:30-5-327.9, 1 page only, issued 6-25-07
317:30-5-1076	317:30-5-1076, 1 page only, revised 6-25-07
317:35-3-2	317:35-3-2, pages 1-3, revised 6-25-07

317:30-5-133.1. Routine services

(a) Nursing facility care includes routine items and services that must be provided directly or through appropriate arrangement by the facility when required by SoonerCare residents. Charges for routine services may not be made to resident's personal funds or to resident family members, guardians or other parties who have responsibility for the resident. If reimbursement is available from Medicare or another public or private insurance or benefit program, those programs are billed by the facility. In the absence of other available reimbursement, the facility must provide routine services from the funds received from the regular SoonerCare vendor payment and SoonerCare resident's applied income, or spend down amount.

(b) The Oklahoma Health Care Authority will review the listing periodically for additions or deletions, as indicated. Routine services are patient specific and in accordance with standard medical care. Routine Services include, but are not limited to:

- (1) Regular room;
- (2) Dietary Services:
 - (A) regular diets,
 - (B) special diets,
 - (C) salt and sugar substitutes,
 - (D) supplemental feedings,
 - (E) special dietary preparations,
 - (F) equipment required for preparing and dispensing tube and oral feedings, and
 - (G) special feeding devices (furnished or arranged for);
- (3) Medically related social services to attain or maintain the highest practicable physical, mental and psycho social well-being of each resident, nursing care, and activities programs (costs for a private duty nurse or sitter are not allowed);
- (4) Personal services - personal laundry services for residents (does not include dry cleaning);
- (5) Personal hygiene items (personal care items required to be provided does not include electrical appliances such as shavers and hair dryers, or individual personal batteries) include:
 - (A) shampoo, comb and brush;
 - (B) bath soap;
 - (C) disinfecting soaps or specialized cleansing agents when indicated to treat or prevent special skin problems or to fight infection;
 - (D) razor and/or shaving cream;
 - (E) nail hygiene services; and
 - (F) sanitary napkins, douche supplies, perineal irrigation

equipment, solutions and disposable douches;

(6) Routine oral hygiene items including:

(A) toothbrushes;

(B) toothpaste;

(C) dental floss;

(D) lemon glycerin swabs or equivalent products; and

(E) denture cleaners, denture adhesives, and containers for dental prosthetic appliances such as dentures and partial dentures.

(7) Necessary items furnished routinely as needed to all patients, e.g., water pitcher, cup and tray, towels, wash cloths, hospital gowns, emesis basin, bedpan, and urinal.

(8) The facility will furnish as needed items such as alcohol, applicators, cotton balls, tongue depressors. Also, first aid supplies including small bandages, ointments and preparations for minor cuts and abrasions, enema supplies, including disposable enemas, gauze, 4 x 4's ABD pads, surgical and micropore tape, telfa gauze, ace bandages, etc.

(9) Over the counter drugs (non-legend) not covered by the prescription drug program (PRN or routine). In general, nursing facilities are not required to provide any particular brand of non-legend drugs, only those items necessary to ensure appropriate care.

(A) If the physician orders a brand specific non-legend drug with no generic equivalent, the facility must provide the drug at no cost to the patient. If the physician orders a brand specific non-legend drug that has a generic equivalent, the facility may choose a generic equivalent, upon approval of the ordering physician;

(B) If the physician does not order a specific type or brand of non-legend drug, the facility may choose the type or brand;

(C) If the member, family, or other responsible party (excluding nursing facility) prefers a specific type or brand of non-legend drug rather than the ones furnished by the facility, the member, family or responsible party may be charged the difference between the cost of the brand the resident requests and the cost of the brand generally provided by the facility. (Facilities are not required to provide an unlimited variety of brands of these items and services. It is the required assessment of resident needs, not resident preferences, that will dictate the variety of products facilities need to provide);

(D) Before purchasing or charging for the preferred items, the facility must secure written authorization from the

member, family member, or responsible party indicating his or her desired preference, the date and signature of the person requesting the preferred item. The signature may not be that of an employee of the facility. The authorization is valid until rescinded by the maker of the instrument;

(10) The facility will furnish or obtain any necessary equipment to meet the needs of the patient upon physician order. Examples include: trapeze bars and overhead frames, foot and arm boards, bed rails, cradles, wheelchairs and/or geriatric chairs, foot stools, adjustable crutches, canes, walkers, bedside commode chairs, hot water bottles or heating pad, ice bags, sand bags, traction equipment, IV stands, etc.;

(11) Physician prescribed lotions, ointments, powders, medications and special dressings for the prevention and treatment of decubitus ulcers, skin tears and related conditions, when medications are not covered under the Vendor Drug Program or other third party payer;

(12) Supplies required for dispensing medications, including needles, syringes including insulin syringes, tubing for IVs, paper cups, medicine containers, etc.;

(13) Equipment and supplies required for simple tests and examinations, including scales, sphygmomanometers, stethoscopes, clinitest, acetest, dextrostix, pulse oximeters, blood glucose meters and test strips, etc.;

(14) Underpads and diapers, waterproof sheeting and pants, etc., as required for incontinence or other care.

(A) If the assessment and care planning process determines that it is medically necessary for the resident to use diapers as part of a plan to achieve proper management of incontinence, and if the resident has a current physician order for adult diapers, then the facility must provide the diapers without charge;

(B) If the resident or the family requests the use of disposable diapers and they are not prescribed or consistent with the facility's methods for incontinent care, the resident/family would be responsible for the expense;

(15) Oxygen for emergency use, or intermittent use as prescribed by the physician for medical necessity;

(16) Other physician ordered equipment to adequately care for the patient and in accordance with standard patient care, including infusion pumps and supplies, and nebulizers and supplies, etc.

(17) Dentures and Related Services. Payment for the cost of dentures and related services is included in the daily rate for routine services. The projected schedule for routine denture

services must be documented on the Admission Plan of Care and on the Annual Plan of Care. The medical records must also contain documentation of steps taken to obtain the service. When the provision of denture services is medically appropriate, the nursing facility must make timely arrangements for the provision of these services by licensed dentists. In the event dentures services are not medically appropriate, the treatment plan must reflect the reason the service is not considered appropriate, i.e., the patient is unable to ingest solid nutrition, comatose, etc. When the need for dentures is identified, one set of complete dentures or partial dentures and one dental examination is considered medically appropriate every three years. One rebase and/or one reline is considered appropriate each three years. It is the responsibility of the nursing facility to ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. The nursing facility cannot set up payment limits which result in barriers to obtaining denture services. However, the nursing facility may restrict the providers of denture services to providers who have entered into payment arrangements with the facility. The facility may also choose to purchase a private insurance dental coverage product for each SoonerCare member. The policy must cover at a minimum all denture services included in routine services. The member cannot be expected to pay any co-payments and/or deductibles. If a difference of opinion occurs between the nursing facility, member, and/or family regarding the provision of dentures services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at the time of admission and yearly thereafter. The member cannot be denied admission to a facility because of the need for denture services.

(18) Vision Services. Routine eye examinations for the purpose of medical screening or prescribing or changing glasses and the cost of glasses are included in the daily rate for routine services. This does not include follow-up or treatment of known eye disease such as diabetic retinopathy, glaucoma, conjunctivitis, corneal ulcers, iritis, etc. Treatment of known eye disease is a benefit of the patient's medical plan. The projected schedule for routine vision care must be documented on the Admission Plan of Care and on the Annual Plan of Care. The medical record must contain documentation of the steps that have been taken to access the service. When vision services are not appropriate, documentation of why vision services are not medically appropriate must be included in the treatment plan. For example, patient is comatose, unresponsive, blind, etc.

Nursing Home providers may contract with individual eye care providers, providers groups or a vision plan to provide routine vision services to their members. The member cannot be expected to pay any co-payments and/or deductibles.

(A) The following minimum level of services must be included:

(i) Individuals 21 to 40 years of age are eligible for one routine eye examination and one pair of glasses every 36 months (three years).

(ii) Individuals 41 to 64 years of age are eligible for one routine eye examination and one pair of glasses every 24 months (2 years).

(iii) Individuals 65 years of age or older are eligible for one routine eye examination and one pair of glasses each 12 months (yearly).

(B) It is the responsibility of the nursing facility to ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. When vision services have been identified as a needed service, nursing facility staff will make timely arrangements for provision of these services by licensed ophthalmologists or optometrists. If a difference of opinion occurs between the nursing facility, member, and/or family regarding the provision of vision services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at admission and yearly thereafter. The member cannot be denied admission to the facility because of the need for vision services.

(19) An attendant to accompany SoonerCare eligible members during SoonerRide Non-Emergency Transportation (NET). Please refer to OAC 317:30-5-326 through OAC 317:30-5-327.9 for SoonerRide rules regarding members residing in a nursing facility.

317:30-5-326. Provider eligibility

The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with 42 CFR 431.53. The agency contracts with a broker to provide statewide curb to curb coverage for non-emergency transportation under the SoonerRide program. The broker provides the most appropriate and least costly mode of transportation necessary to meet the individual needs of SoonerCare members. Payment for covered services to the broker is reimbursed under capitated methodology based on per member per month. The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not approved by SoonerRide.

317:30-5-326.1. Definitions

The following words and terms, when used in this subchapter have shall have the following meaning, unless context clearly indicates otherwise.

"Attendant" means an employee of the nursing facility who is provided by and trained by the nursing facility at the nursing facility's expense.

"Escort" means a family member or legal guardian whose presence is required to assist a member during transport and while at the place of treatment. An escort voluntarily accompanies the member during transport and leaves the vehicle at its destination and remains with the member. An escort must be of an age of legal majority recognized under State law.

"Member/eligible member" means any person eligible for SoonerCare with the exception of those individuals who are categorized as Qualified Medicare Beneficiaries Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB), Qualifying Individuals-1, individuals who are in an institution for mental disease (IMD), inpatient, institutionalized, Home and Community Based Waiver members, with the exception of the In-home Supports Waiver for Children and the Advantage Waiver.

317:30-5-327. SoonerRide non-emergency non-ambulance transportation eligibility

Transportation must be for medically necessary treatment in accordance with 42 CFR 441.170. SoonerRide excludes those individuals who are categorized as:

- (1) Qualified Medicare Beneficiaries Plus (QMBP);
- (2) Specified Low Income Medicare Beneficiaries (SLMB);
- (3) Qualifying Individuals-1 and individuals who are in an institution for mental disease (IMD);
- (4) inpatient;
- (5) institutionalized;
- (6) Home and Community Based Waiver members, with the exception of the In-home Supports Waiver for Children and the Advantage Waiver.

317:30-5-327.1. Access to non-emergency non-ambulance transportation through SoonerRide

(a) Non-emergency, non-ambulance transportation services are available through the state's SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all eligible members.

(b) SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. Eligible providers are providers who have valid OHCA contracts. The NET must be to access medically necessary covered services for which a member has available benefits. Additionally, SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare.

(c) The use of SoonerCare funded transportation for any other purpose is fraudulent activity and subject to criminal prosecution and civil and administrative sanctions.

(d) The SoonerRide broker assures that NET transportation services are provided:

- (1) in a manner consistent with the best interest of the member;
- (2) similar in scope and duration state-wide, although there will be some variation based on available resources in a particular geographical area of the state;
- (3) appropriate to available services; and
- (4) appropriate for the limitations of the member.

317:30-5-327.2. Service availability

(a) SoonerRide NET is available for SoonerCare covered admission and discharge into inpatient hospital care, outpatient hospital care, services from physicians, diagnostic devices, clinic services, pharmacy services, eye care and dental care.

(b) SoonerRide NET is available if a member is being discharged from a facility to home. The facility is responsible for scheduling the transportation.

(c) In documented medically necessary instances, a family member or legal guardian may wish to accompany the member for health care services. In such instances, the family member or legal guardian may accompany the member.

(1) SoonerRide is not required to transport any additional family members other than the one family member providing escort services. In the event that additional family members request transportation, the SoonerRide broker may charge those family members according to the SoonerRide broker's policies which have been approved by the OHCA.

(2) An escort is not eligible for direct compensation by the SoonerRide broker or SoonerCare.

MEDICAL PROVIDERS-FEE FOR SERVICE

SOONERRIDE NON-EMERGENCY TRANSPORTATION OAC 317:30-5-327.3 (p1)

317:30-5-327.3. Coverage for residents of nursing facilities

(a) An attendant must accompany members during SoonerRide Non-Emergency Transportation (NET). An attendant must be at least at the level of a nurse's aide, and must have the appropriate training necessary to provide any and all assistance to the member, including physical assistance needed to seat the member in the vehicle. The attendant must have the ability to interface with health care providers as appropriate. An attendant must be of an age of legal majority recognized under State law.

(1) The nursing facility must provide an attendant to accompany members receiving NET services.

(2) The attendant will be responsible for any care needed by the member(s) during transport and any assistance needed by the member(s) to assure the safety of all passengers and the driver of the vehicle. An attendant leaves the vehicle at its destination and remains with the member(s).

(3) When multiple members residing in the same nursing facility are being transported to the same provider for health care services, the nursing facility may provide one qualified attendant for each three members unless other circumstances indicate the need for additional attendants. Such circumstances might include but are not limited to:

(A) the physical and/or mental status of the member(s),

(B) difficulty in getting the member(s) in and out of the vehicle,

(C) the amount of time that a member(s) would have to wait unattended, etc.

(4) SoonerRide is not responsible for arranging for an attendant. The services of the attendant are not directly reimbursable by the SoonerRide program or SoonerCare. The cost for the attendant is included in the SoonerCare nursing facility per diem rate.

(5) In certain instances, a family member or legal guardian may wish to accompany the member for health care services. In such instances, the family member or legal guardian may accompany the member in place of the attendant. Only one escort may accompany a member. The escort must be able to provide any services and assistance necessary to assure the safety of the member in the vehicle.

(A) When an escort wishes to accompany the member in place of an attendant provided by the nursing facility, the escort and the nursing facility must sign a release form stating that an escort will be traveling with the member and performing the services which would normally be performed by the attendant.

This release must be faxed to the SoonerRide broker's

MEDICAL PROVIDERS-FEE FOR SERVICE

SOONERRIDE NON-EMERGENCY TRANSPORTATION OAC 317:30-5-327.3 (p2)

business office prior to the date of the transport.

(B) If an escort is used in place of an attendant provided by the nursing facility, that escort cannot be counted as an escort for any other member who is traveling in the same vehicle.

(C) SoonerRide is not required to transport any additional family members other than the one family member providing escort services. In the event that additional family members request transportation, the SoonerRide broker may charge those family members according to the SoonerRide broker's policies approved by the OHCA.

(D) An escort is not eligible for direct compensation by the SoonerRide broker or SoonerCare.

(b) For members who require non-emergency transportation for dialysis, one attendant is required to accompany a group of up to three dialysis patients when they are being transported for dialysis services. The attendant must remain with the patient(s) unless the provider of the dialysis treatment and the nursing facility sign a release form stating that the presence of the attendant is not necessary during the dialysis treatment. The release must be faxed to the SoonerRide broker's business office prior to the date of the dialysis service.

(1) In instances when an attendant does not remain with the member(s) during dialysis treatment, SoonerRide is not responsible for transporting the attendant back to the nursing facility.

(2) In instances when an attendant does not remain with the member(s) during dialysis treatment, the nursing facility is responsible for providing an attendant to accompany the member(s) on the return trip from the dialysis center. The nursing facility is also responsible for transporting that attendant to the dialysis center in order to accompany the member(s) on the return trip.

(c) In the event that a member is voluntarily moving from one nursing facility to another, SoonerRide will provide NET to the new facility. The nursing facility that the member is moving from will be responsible for scheduling the transportation and providing an attendant for the member.

(d) In the event that a nursing facility's license is terminated, SoonerRide will provide NET to a new nursing facility. The nursing facility that the member is moving from will be responsible for scheduling the NET through SoonerRide and providing an attendant to accompany the member.

317:30-5-327.4. Coverage for children

(a) Services, deemed medically necessary and allowable under federal Medicaid regulations, may be covered by the EPSDT/OHCA Child Health program even though the services may not be part of the OHCA SoonerCare program. Such services must be prior authorized.

(b) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

317:30-5-327.5. Exclusions from SoonerRide NET

SoonerRide NET excludes:

(1) transportation of members to access emergency services;

(2) transportation of members by ambulance for any reason;

(3) transportation of members whose medical condition requires transport by stretcher;

(4) transportation of members to services that are not covered by SoonerCare; and

(5) transportation of members to services that are not medically necessary.

317:30-5-327.6. Denial of SoonerRide NET services by the SoonerRide broker

(a) In addition to the exclusions listed in 317:30-5-327.5 of this Part, the SoonerRide broker may deny NET services if:

(1) the nursing facility/member refuses to cooperate in determining the member's eligibility;

(2) the nursing facility/member refuses to provide the documentation required to determine the medical necessity for NET services;

(3) the member or attendant exhibits uncooperative behavior or misuses/abuses NET services;

(4) the member is not ready to board NET transport at the scheduled time or within 10 minutes after the scheduled pick up time; and

(5) the nursing facility/member fails to request a reservation at least three days in advance of a health care appointment without good cause. Good cause is created by factors such as, but not limit to any of the following:

(A) urgent care;

(B) post-surgical and/or medical follow up care specified by a health care provider to occur in fewer than three days;

(C) imminent availability of an appointment with a specialist when the next available appointment would require a delay of two weeks or more; and

(D) the result of administrative or technical delay caused by SoonerRide and requiring that an appointment be rescheduled.

(b) Pursuant to Federal law, SoonerRide will provide notification in writing to nursing facilities/member when members have been denied services. This notification must include the specific reason for the denial and the member's right to appeal.

317:30-5-327.7. SoonerRide provider network

(a) The SoonerRide broker will maintain an adequate number of appropriate network providers to provide non-emergency, non-ambulance transportation services for eligible members.

(b) If a nursing facility has the capability to provide non-emergency, non-ambulance transportation, the SoonerRide broker may contract with the nursing facility as a NET network provider. The nursing facility must meet the same standards as any other SoonerRide contracted provider for vehicle and driver licensing, safety, training, liability, and ADA regulations. Additionally, when a nursing facility is contracted as a NET provider, the nursing facility cannot limit transportation services to members of a specific nursing facility, but must have the same availability as any other contracted network provider except for the transportation of members for dialysis services.

(c) SoonerRide may contract with other transportation providers solely for the non-emergency, non-ambulance transportation of members for dialysis services.

317:30-5-327.8. Type of services provided and duties of the SoonerRide driver

(a) The SoonerRide NET program is limited to curb-to-curb services. Curb-to-curb services are defined as services for which the vehicle picks up and discharges the passengers at the curb or driveway in front of their place of residence or destination. The SoonerRide NET driver does not provide assistance to passengers along walkways or steps to the door or the residence or other destination. The SoonerRide NET driver will open and close the vehicle doors, load or provide assistance with loading adaptive equipment. Additionally, the SoonerRide NET driver may fasten and unfasten safety restraints when that service is requested by the rider or on behalf of the rider.

(b) If the member is traveling by lift van, the SoonerRide NET driver will load and unload the member according to established protocols for such procedures approved by the Oklahoma Health Care Authority.

(c) The SoonerRide NET driver will deliver the member to the scheduled destination, and is not required to remain with the member.

317:30-5-327.9. Scheduling NET services through SoonerRide

(a) The nursing facility/member will schedule SoonerRide NET services for transportation to covered services. SoonerRide NET services may be scheduled by calling the toll free SoonerRide number or by faxing a request to SoonerRide.

(b) All SoonerRide NET routine services must be scheduled by advance appointment. Appointments must be made at least three business days in advance of the health care appointment, but may be scheduled up to fourteen business days in advance. Scheduling for members with standing appointments may be scheduled for those appointments beyond the 14 days.

(c) NET services for eligible members will be scheduled and obtained through the SoonerRide NET program. The nursing facilities/member will be financially responsible for NET services which are not scheduled for eligible members through the SoonerRide program. The nursing facility may not charge the member or member's family for NET services which were not paid for by SoonerRide because they were not scheduled through SoonerRide in the appropriate manner.

(d) Whenever possible SoonerRide will give consideration for members who request NET for routine care and the request is made less than three business days in advance of the appointment. However, such requests for service are not guaranteed and will depend on the available space and resources.

(e) If SoonerRide cannot provide NET for urgent care, the nursing facility/member may provide the NET transportation and submit proper documentation to SoonerRide for reimbursement. In such cases the nursing facility/member must attempt to schedule the service through SoonerRide first, and obtain a reference number or the service must have become necessary during a time that SoonerRide scheduling was unavailable, such as after hours or weekends. For NET for urgent services provided after hours or on weekends, the nursing facility/member must notify SoonerRide within two business days of the date of service.

317:30-5-1076. Coverage by category

Payment is made for Nutritional Services as set forth in this section.

(1) **Adults.** Payment is made for six hours of medically necessary nutritional counseling per year by a licensed registered dietician. All services must be prescribed by a physician, physician assistant, advanced practice nurse, or nurse midwife and be face to face encounters between a licensed registered dietitian and the member. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness. Nutritional services for the treatment of obesity is not covered unless there is documentation that the obesity is a contributing factor in another illness.

(2) **Children.** Coverage for children is in accordance with OAC 317:30-3-47.

(3) **Home and Community Based Waiver Services for the Mentally Retarded.** All providers participating in the Home and Community Based Waiver Services for the Mentally Retarded program must have a separate contract with OHCA to provide Nutrition Services under this program. All services are specified in the individual's plan of care.

(4) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Services which are not covered under Medicare should be billed directly to OHCA.

317:35-3-2. SoonerCare transportation and subsistence

The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with 42 CFR 431.53. The agency contracts with a broker to provide statewide curb to curb coverage for non-emergency transportation under the SoonerRide program. The broker provides the most appropriate and least costly mode of transportation necessary to meet the individual needs of SoonerCare members. Payment for covered services to the broker is reimbursed under a capitated methodology based on per member per month. The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not provided by SoonerRide. SoonerRide excludes those individuals who are categorized as:

- (1) Qualified Medicare Beneficiaries Plus (QMBP);
- (2) Specified Low Income Medicare Beneficiaries (SLMB);
- (3) Qualifying Individuals-1;
- (4) individuals who are in an institution for mental disease (IMD), inpatient;
- (5) institutionalized;
- (6) Home and Community Based Waiver members with the exception of the In-home Supports Waiver for Children and the ADvantage Waiver.

(b) Members seeking medically necessary non-emergency transportation will be required to contact the SoonerRide reservation center. Contact will be made via a toll-free phone number which is answered Monday through Saturday, 8 a.m. to 6 p.m. Whenever possible, the member is required to notify SoonerRide at least 72 hours prior to the appointment. The member is asked to furnish the SoonerRide reservation center their SoonerCare member number, home address, the time and date of the medical appointment, the address and phone number of the medical provider, and any physical/mental limitations which will impact the type of transportation needed. SoonerRide makes arrangements for the most appropriate, least costly transportation. SoonerRide verifies appointments when appropriate. If the member disagrees with the transportation arranged or denied by SoonerRide, an appeal must be filed with OHCA according to OAC 317:2-1-2. The appropriateness of transportation may be appealed only to the extent that the transportation does not meet the medical needs of the member. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal. The Oklahoma Health Care Authority's decision is final.

(1) Authorization for transportation by private vehicle or bus.

Transportation by private vehicle or bus is administered through the broker when it is necessary for an eligible member to receive medical services.

(2) Authorization for transportation by taxi. Taxi service may be authorized at the discretion of the broker.

(3) Transportation by ambulance (ground, air ambulance or helicopter). Transportation by ambulance is compensable for individuals eligible for SoonerCare benefits when other available transportation does not meet the medical needs of the individual. Payment is made for ambulance transportation to and/or from a medical facility for medical care compensable under SoonerCare.

(4) Transportation by airplane. When an individual's medical condition is such that transportation out-of-state by a commercial airline is required, approval for airfare must be secured by telephoning the OHCA who will make the necessary flight arrangements.

(5) Subsistence (sleeping accommodations and meals). An individual who is eligible for transportation to or from a medical facility to obtain medical services may receive assistance with the necessary expenses of lodging and meals from SoonerCare funds. If the individual needs assistance with necessary expenses of lodging and meals, the member may pay for the lodging and meals and then submit a travel reimbursement form for reimbursement; if the member does not have the funds for the necessary subsistence, authorization is made by the local office on the Room and Board Order form. The travel reimbursement form may be obtained by contacting OHCA or the local OKDHS office. Any subsistence expense claimed on the travel reimbursement form must be documented with receipts, and reimbursement cannot exceed state per diem amounts. Payment for meals is only provided for overnight stays that are more than 50 miles from the home and are based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.

(6) Escort assistance required. Payment for transportation and subsistence of one escort may be authorized if the service is required. Only one escort may be authorized. It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:

(A) when the individual's health does not permit traveling alone; and

(B) when the individual seeking medical services is a minor

child.