
POLICY TRANSMITTAL NO. 05-50	DATE: OCTOBER 25, 2005
FAMILY SUPPORT SERVICES DIVISION/OKLAHOMA HEALTH CARE AUTHORITY	DEPARTMENT OF HUMAN SERVICES OFFICE OF PLANNING, POLICY & RESEARCH

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-3-20.1; 30-5-14; 30-5-42; 30-5-72; 30-5-129; 30-5-525 through 30-5-527; 310-5-530 through 30-5-532; 30-5-555 through 560.2; 35-7-38; and 35-10-38.

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

Eligibility rules are revised to clarify who may be considered temporarily absent from the home when determining financial eligibility for the benefit group and to correct scrivener errors and reflect current practice.

Fee for Service rules are: (1) issued to establish a formal appeals process specifically for pharmacy providers; (2) revised to establish an exclusion effective 1-1-06 from the prescription drug benefit for individuals who qualify for the Medicare Part D benefit; and (3) revised to correct scrivener errors, reorganize rules to reflect current practice and align rules with other rules within the Administrative Code.

Rules are revised to allow for the payment of hospice services for children who have been certified by their physician as having a terminal illness and a life expectancy of less than six months.

Provider rules are revised to (1) allow payment for allergy injections administered under the supervision of the contracted provider; and (2) to establish rules for private duty nursing care provided Medicaid eligible children.

Original signed on 10-25-05

Mary Stalnaker, Director
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WF # 05-BB (DT)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

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

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

REMOVE

INSERT

317:30-3-20.1

317:30-3-20.1, pages 1-2, issued 7-11-05

317:30-5-14

317:30-5-14, pages 1-3, revised 8-1-05

317:30-5-42

317:30-5-42, pages 1-3, revised 8-1-05

317:30-5-72

317:30-5-72, pages 1-2, revised 7-11-05

317:30-5-129

317:30-5-129, 1 page only, revised 7-11-05

317:30-5-525

317:30-5-526

317:30-5-527

317:30-5-530, 1 page only, issued 8-1-05

317:30-5-531, 1 page only, issued 8-1-05

317:30-5-532, 1 page only, issued 8-1-05

317:30-5-555, 1 page only, issued 8-1-05

317:30-5-556, 1 page only, issued 8-1-05

317:30-5-557, 1 page only, issued 8-1-05

317:30-5-558, pages 1-2, issued 8-1-05

317:30-5-559, 1 page only, issued 8-1-05

REMOVE

317:35-7-38

317:35-10-38

INSERT

317:30-5-560, pages 1-2, issued 8-1-05

317:30-5-560.1, 1 page only, issued 8-1-05

317:30-5-560.2, 1 page only, issued 8-1-05

317:35-7-38, pages 1-4, revised 7-11-05

317:35-10-38, 1 page only, issued 7-11-05

317:30-3-20.1 Pharmacy grievance procedures and processes

This section shall apply to Pharmacy Providers for appeals to findings of audits conducted by the OHCA Pharmacy department. Aggrieved providers may appeal to a subcommittee of the Drug Utilization Review Board.

(1) If a provider disagrees with a decision of the OHCA Pharmacy department audit team which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision, the decision to a three member subcommittee of the Drug Utilization Review Board (DURB). The subcommittee shall consist of three of the four pharmacist members of the DURB. In the event that there are less than three pharmacist members appointed at any given time, the panel will be completed with other DURB members.

(2) The appeal from the OHCA Pharmacy department audit team decision shall 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 shall also include all relevant exhibits the provider believes necessary to decide the appeal.

(3) Upon the receipt of the appeal by the docket clerk, the matter shall be docketed for the next meeting of the DURB. Any appeal received less than three weeks before a scheduled DURB meeting will be set for the following DURB meeting.

(4) The appeal shall be forwarded to the OHCA Pharmacy Department Audit Team by the docket clerk for distribution to the members of the subcommittee and for preparation of the OHCA's case.

(5) At the discretion of the DURB, 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 Authority be present during their consideration of the appeal. Members of the Authority's Legal Division may be asked to answer legal questions regarding the appeal.

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

(7) The recommendation, after being formalized, shall be sent to the docket clerk for review by the State Medicaid Director. The State Medicaid Director shall issue a decision regarding the appeal within 10 days of the docket clerk's receipt of the recommendation from the DURB. The decision shall 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 OHCA CEO under OAC 317:2-1-4(1).

317:30-5-14. Injections

(a) Coverage for injections is limited to those categories of drugs included in the vendor drug program for Medicaid. OHCA administers and maintains an open formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The Authority covers any drug for its approved purpose that has been approved by the Food and Drug Administration (FDA). Administration of injections is paid in addition to the medication.

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

(2) **Immunizations for adults.** Coverage for adults is limited to:

(A) influenza immunizations,

(B) Pneumococcal Immunizations, and

(C) Gamma Globulin and Hepatitis A Vaccine when documentation shows the individual has been exposed to Hepatitis.

(b) The following drugs, classes of drugs or their medical uses are excluded from coverage:

(1) Agents used for the treatment of anorexia, weight gain, or obesity;

(2) Agents used to promote fertility;

(3) Agents used to promote hair growth;

(4) Agents used for cosmetic purposes;

(5) Agents used for the symptomatic relief of coughs and colds. Cough and cold drugs are not covered;

(6) Agents that are experimental or whose side effects make usage controversial; and

(7) Vitamins and Minerals with the following exception:

(A) Vitamin B-12 is covered only when there is a documented occurrence of malabsorption disease;

(B) Vitamin K injections are compensable; and

(C) Iron injections when medically necessary and documented by objective evidence of failure to respond to oral iron.

(c) Use the appropriate HCPC code when available. When drugs are billed under miscellaneous codes, a paper claim must be filed. The claims must contain the drug name, strength, dosage amount, and National Drug Code (NDC).

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

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

(f) Trigger point injections (TPI's) are covered using appropriate CPT codes. Modifiers are not allowed for this code. Payment is made for up to three injections (3 units) per day at the full allowable. Payment is limited to 12 units per month. The medical records must clearly state the reasons why any TPI services were medically necessary. All trigger point records must contain proper documents and be available for review. Any services beyond 12 units per month or 36 units per 12 months will require mandatory review for medical necessity. Medical records must be automatically submitted with any claims for services beyond 36 units.

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

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PHYSICIANS SPECIFIC**

OAC 317:30-5-14 (p3)

injection. The same guidelines apply to aspirations.

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

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

317:30-5-42. Coverage for children

Payment is made to hospitals for medical and surgical services for persons under the age of 21 within the scope of the Authority's Medical Programs, provided the services are reasonable for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services are comparable to those listed for adults except as follows.

(1) **Inpatient general acute care services limitations.** All medically necessary inpatient hospital services, other than psychiatric services, for all persons under the age of 21 will not be limited.

(2) **Utilization control requirements for psychiatric beds.** Medicaid utilization control requirements applicable to inpatient psychiatric services for persons under 21 years of age in psychiatric facilities apply to acute care hospitals. Acute care hospitals are required to maintain the same level of documentation on individuals receiving psychiatric services as the free-standing psychiatric facilities (refer to OAC 317:30-5-95.2).

(3) **Outpatient hospital services.** Payment is made for outpatient hospital services, including lab and x-rays.

(4) **Outpatient physical therapy.** Payment is made for preauthorized outpatient physical therapy. Payment is limited to four visits per month.

(5) **Hospice Services.** Hospice is palliative and/or comfort care provided to the client and his/her family when a physician certifies that the client has a terminal illness and has six months or less to live and orders hospice care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The hospice services must be related to the palliation and management of the client's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Payment is made for home based hospice services for terminally ill individuals with a life expectancy of six months

or less when the patient and/or family has elected hospice benefits in lieu of standard Medicaid services that have the objective to treat or cure the client's illness. Once the client has elected hospice care, the hospice medical team assumes responsibility for the client's medical care for the terminal illness in the home environment. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the client and/or family. Services must be prior authorized. Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the patient's lifetime. However, the patient and/or the family may voluntarily terminate hospice services. To be covered, hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the individual is terminally ill must be completed by the patient's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness. A plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

(6) **Exclusions.** The following are excluded from coverage:

- (A) Inpatient diagnostic studies that could be performed on an outpatient basis.
- (B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.
- (C) Sterilization of persons who are under 21 years of age.
- (D) Reversal of sterilization procedures for the purposes of conception.
- (E) Hysterectomy, unless therapeutic and unless a copy of an acknowledgment form, signed by the patient or an acknowledgment by the physician that the patient has already been rendered sterile is attached to the claim.

(F) Medical services considered to be experimental.

317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six covered prescriptions per month with a limit of three brand name prescriptions.

(2) Subject to the limitations set forth in OAC 317:30-5-72.1, OAC 317:30-5-77.2, and OAC 317:30-5-77.3, exceptions to the six medically necessary prescriptions per month limit are:

(A) Unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded; and

(B) seven additional medically necessary prescriptions which are generic products per month to the six covered under the State Plan are allowed for adults receiving services under the '1915(c) Home and Community Based Services Waivers. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization.

(3) Drugs exempt from the prescription limit include: Antineoplastics, anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV), certain prescriptions that require frequent laboratory monitoring, birth control prescriptions, over the counter contraceptives, hemophilia drugs, compensable smoking cessation products, low-phenylalanine formula and amino acid bars for persons with a diagnosis of PKU, certain solutions used in compounds (i.e. sodium chloride, sterile water, etc.), and drugs used for the treatment of tuberculosis. For purposes of this Section, exclusion from the prescription limit means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month.

(b) **Coverage for children.** Prescription drugs for Medicaid eligible individuals under 21 years of age are not limited.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are eligible for a prescription drug benefit provided that the dispensing pharmacy has exhausted payment from the Medicare intermediary for any Part B compensable drugs.

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

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

OAC 317:30-5-129

317:30-5-129. Required monthly notifications

(a) The Notification Regarding Patient in a Nursing Facility or ICF/MR form is completed and forwarded to the local DHS office by the facility each time a recipient is admitted to or discharged from the facility except for therapeutic leave or hospital leave.

(b) A Computer Generated Notice or the Notice to Client Regarding Long-Term Medical Care form is used by the county office to notify the recipient and the facility of the amount of money, if any, the recipient is responsible for paying to the facility and the action taken with respect to the patient's eligibility for nursing facility care. This form reflects dates of transfer between facilities and termination of eligibility for any reason.

317:30-5-530. Eligible providers

Non-Hospital Affiliated Hospice entities must be appropriately licensed and have a contract with the Oklahoma Health Care Authority to provide Hospice services.

317:30-5-531. Coverage for adults

There is no coverage for hospice services provided Medicaid eligible adults except for the hospice provision provided through the ADvantage Waiver.

317:30-5-532. Coverage for children

Hospice is palliative and/or comfort care provided to the client and his/her family when a physician certifies that the client has a terminal illness and has six months or less to live and orders hospice care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The hospice services must be related to the palliation and management of the client's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Payment is made for home based hospice services for terminally ill individuals with a life expectancy of six months or less when the patient and/or family has elected hospice benefits in lieu of standard Medicaid services that has the objective to treat or cure the client's illness. Once the client has elected hospice care, the hospice medical team assumes responsibility for the client's medical care for the terminal illness in the home environment. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the client and/or family. Services must be prior authorized. Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the patient's lifetime. However, the patient and/or the family may voluntarily terminate hospice services. To be covered, hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the individual is terminally ill must be completed by the patient's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness. A plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

317:30-5-555. Eligible providers

(a) An organization who desires to be paid by Oklahoma Medicaid for private duty nursing must meet the following requirements prior to providing services to eligible Medicaid beneficiaries:

(1) an executed contract with OHCA, and

(2) the organization must meet the requirements of OAC 317:30-5-545 or it must be licensed by the State Health Department as a Home Care Agency.

(b) The provider of services within the organization must be a licensed practical nurse or a registered nurse.

317:30-5-556. Definitions

The definition of private duty nursing is medically necessary care provided on a regular basis by a Licensed Practical Nurse or Registered Nurse in the patient's residence.

317:30-5-557. Coverage by category

(a) **Adults.** Oklahoma Medicaid does not cover adults (persons age 21 or over) for private duty nursing with the exception of subsection (c).

(b) **Children.** Oklahoma Medicaid does cover children (Persons under the age of 21) if:

(1) the child is eligible for Medicaid and

(2) the Oklahoma Health Care Authority, in its discretion, deems the services medically necessary. Medical necessity is determined in accordance with OAC 317:30-5-560.1.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

317:30-5-558. Private duty coverage limitations

(a) The following regulations apply to all private duty nursing services and provide coverage limitations:

(1) All services must be prior authorized to receive payment from the Medicaid agency. Prior authorization means authorization in advance of services provided in accordance with OAC 317:30-5-560.1;

(2) A treatment plan must be completed prior to the prior authorization and must be updated throughout the course of nursing treatment;

(3) A personal visit by an Oklahoma Health Care Authority Care Management Nurse is required prior to the authorization for services;

(4) Care in excess of the designated hours per day granted in the prior authorization are not compensable. The banking, saving or accumulation of unused prior authorized hours to be used later are not compensable.

(5) The agency requesting prior authorization must have adequate staff and resources to meet the Plan of Care requirements. Failure to provide care in the manner described on the Plan of Care will result in termination of the prior authorization and selection of another provider.

(6) Private duty nursing services does not include office time or administrative time in providing the service. The time billed is for direct nursing services only.

(7) Staff must be engaged in purposeful activity that directly benefit the person receiving services. Staff must be physically able and mentally alert to carry out the duties of the job. At no time will the Authority compensate an organization for nursing staff time when sleeping.

(8) OHCA will not compensate service if all health and safety issues cannot be met in the home setting.

(9) A provider may not misrepresent facts in a treatment plan or omit facts from a treatment plan.

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PRIVATE DUTY NURSING**

OAC 317:30-5-558 (p2)

(10) It is outside the scope of coverage to deliver care in a manner outside the treatment plan or to deliver units over the authorized units of care.

(11) Private duty nursing will not be authorized in excess of 16 hours per day except immediately following a hospital stay or the temporary incapacitation of the primary caregiver. Under these two exceptions, care in excess of 16 hours may be authorized for a period up to 30 days. As expressed in this subsection, incapacity means an involuntary ability to provide care.

(12) Family and/or caregivers and/or guardians are required to provide some of the nursing care without compensation.

(b) A violation of any private duty nursing coverage limitations will result in an overpayment. Continued violations may result in contract termination.

317:30-5-559. How services are authorized

An eligible provider may have private duty nursing services authorized by following all the following steps:

(1) create a treatment plan for the patient as expressed in OAC 317:30-5-560;

(2) request a home visit by an OHCA Care Management Nurse; and

(3) have an OHCA Care Management Nurse determine medical necessity of the service by scoring the client's needs on the Private Duty Nursing Acuity Grid (Form OHCA-26).

317:30-5-560. Treatment Plan

(a) An eligible organization must create a treatment plan for the patient as part of the process to have private duty nursing services authorized. The treatment plan must be signed by the patient's attending physician.

(b) The treatment plan must include all of the following medical and social data so that OHCA Care Managers can appropriately determine medical necessity by the use of the Private Duty Nursing Acuity Grid:

(1) diagnosis

(2) prognosis

(3) anticipated length of treatment

(4) number of hours of private duty nursing requested per day

(5) assessment needs and frequency (e.g., vital signs, glucose checks, neuro checks, respiratory)

(6) medication method of administration and frequency

(7) age appropriate feeding requirements (diet, method and frequency)

(8) respiratory needs

(9) mobility requirements including need for turning and positioning, and the potential for skin breakdown

(10) developmental deficits

(11) casting, orthotics, therapies

(12) age appropriate elimination needs

(13) seizure activity and precautions

(14) age appropriate sleep patterns

(15) disorientation and/or combative issues

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OAC 317:30-5-560 (p2)

(16) age appropriate wound care and/or personal care

(17) communication issues

(18) social support needs

(19) name, skill level, and availability of all caregivers

(20) other pertinent nursing needs such as dialysis, isolation.

317:30-5-560.1. Prior authorization requirements

(a) Authorizations are provided for a maximum period of six months.

(b) Authorizations may only be received by creating a treatment plan for the patient, requesting a visit by an OHCA Care Management Nurse, and having the Care Management Nurse determine medical necessity by scoring the client's needs on the Private Duty Nursing Acuity Grid. The number of hours requested on the treatment plan may be modified based on the assessment of OHCA staff during a visit by a Care Management Nurse. If the patient's condition necessitates a change in the treatment plan, the provider must request a new prior authorization.

(c) Changes in the treatment plan may necessitate another visit by the Care Management staff.

317:30-5-560.2. Record documentation

Copies of the treatment plan signed by the attending physician.
Copies of the attending physician's orders and, at a minimum, the
last 30 days of medical records for the actual care provided must
be maintained in the home. Medical records must include the
beginning and ending time of the care and must be signed by the
person providing care. The nurse's credentials must also be
included. All provisions of the treatment plan, such as vital
signs, medication administration, glucose/neuro checks, vital
signs, respiratory assessments, and all applicable treatments must
be documented in the record. All records must meet the
requirements set forth in OAC 317:30-3-15.

317:35-7-38. Financial eligibility of categorically needy individuals related to ABD

(a) **Income and resources below State Supplemental Payment (SSP) standard.** Individuals whose income and resources meet SSP requirements on OKDHS Appendix C-1, Schedules VIII. A. and D., are considered categorically needy.

(1) **Categorical Relationship.** For an individual categorically related to ABD to be categorically needy at the SSP standard, the countable income must be less than the standards on OKDHS Appendix C-1, Schedule VIII. A. and the equity in capital resources cannot exceed the maximum allowable resources on OKDHS Appendix C-1, Schedule VIII. D. for the following groups:

(A) An eligible individual. An eligible individual is a single individual who is aged, blind or disabled and has total countable income less than the "Categorically Needy Standard for an Eligible Individual";

(B) An eligible individual and essential spouse. An essential spouse is defined as having been continuously included in the case since prior to 1974. The total countable income of both must be less than the "Categorically Needy Standard for Eligible Individual with Essential or Ineligible Spouse";

(C) An eligible individual and ineligible spouse. An ineligible spouse does not meet the definition of aged, blind or disabled nor the requirement as "essential". The total countable income of the eligible individual must be less than the "Categorically Needy Standard for Eligible Individual", and the total countable income of both must be less than the "Categorically Needy Standard for Eligible Individual with Essential or Ineligible Spouse";

(D) An eligible individual with a spouse ineligible for ABD and dependent children.

(i) If the spouse and dependent children are included in a TANF diversion payment or ongoing TANF benefits, their income is not deemed to the ABD eligible individual.

(ii) If the spouse's needs are not included in the TANF case for the children, the portion of the spouse's income

that is considered in determining the grant for the children is not considered in the SSP case;

(E) An eligible couple. An eligible couple means a husband and wife who are both either aged, blind or disabled and have total countable income less than the "Categorically Needy Standard for Eligible Couple".

(2) **Verification.** Verification of receipt of SSI establishes financial eligibility with these exceptions:

(A) Countable income including SSI cannot be equal to or exceed the appropriate Categorically Needy Standards on OKDHS Appendix C-1, Schedule VIII. A.

(B) The individual must meet the OHCA's requirements on irrevocable burial funds.

(3) **Related to ABD.** Individuals who meet the definition of categorically needy with income below the SSP standard and categorically related to ABD are:

(A) Individuals in an active ABD case.

(B) Individuals categorically related to ABD whose countable income and resources are within current SSP standards for eligibility but who do not choose to receive financial assistance.

(C) Individuals in ABD cases who are eligible for Medicaid due to the disregard of Social Security cost of living increases (COLA) under the Pickle Amendment. An individual is eligible under the Pickle Amendment if the following conditions are met:

(i) is currently receiving OASDI;

(ii) has been eligible for and simultaneously received both OASDI and SSP for at least one month since April, 1977;

(iii) lost eligibility for SSP since April, 1977; and

(iv) would be eligible for SSP if OASDI COLA increases received since the closure of SSP case were deducted from

countable income.

(D) Spouses "grandfathered in" as essential persons to ABD recipients when the ABD case load was converted to SSI on January 1, 1974, so long as they continue as an essential person to an eligible ABD recipient converted to SSI (even though there is a change in category within ABD).

(E) Individuals in ABD cases who continue to be eligible for Medicaid because the Social Security Administration has determined that they still qualify as "disabled" (by classifying as 1619(b) of the Social Security Act) even though they become employed and lose eligibility for SSI benefits due to the earned income. To retain Medicaid eligibility, the individual must have received Medicaid for the month prior to the determination by SSA. Income and resources excluded by SSA are also disregarded by OKDHS for these individuals. The county is responsible for the periodic redetermination of eligibility. The individual who meets all other factors of eligibility without consideration of income, resources or disability remains eligible until the SSI status changes.

(F) Individuals in blind or disabled cases who have become ineligible for SSP because of becoming entitled to or receiving an increase in OASDI (Title II) Widow's/Widower's benefits. They may continue to qualify for Medicaid as categorically needy until age 65 or upon entitlement to Medicare Part A benefits if they also meet the following criteria:

- (i) Are at least 60 but not yet 65;
- (ii) Are not entitled to Medicare;
- (iii) Received SSI prior to age 60; and
- (iv) Meet all other factors of eligibility.

(G) Individuals in blind or disabled cases who become ineligible for SSP due to entitlement of OASDI (Title II) Disabled Widow's/Widower's and Disabled Surviving Divorced Spouse's benefits. This group's eligibility as categorically needy terminates at age 65 or upon entitlement to Medicare Part A benefits. Each month the individual received SSI/SSP

will count toward meeting the 24-month Medicare waiting period. This may greatly reduce or even eliminate the normal waiting period of Medicare. Care must be taken to determine if and when these individuals become eligible for Medicare Part A benefits. This group's Medicaid eligibility may continue if they also meet the following criteria:

(i) Received SSP for the month prior to the month they began receiving the OASDI benefits;

(ii) Not entitled to Medicare Part A; and

(iii) Meet all other factors of Medicaid eligibility.

(H) A, B or D recipients (who are at least 18 years of age) who have become ineligible for an SSP due to the receipt of or increase in OASDI child's benefits [Disabled Adult Child (DAC)] which are based on their own disability.

(I) A, B or D recipients who lost their SSP eligibility due to a reduction in the maximum SSP payment. (OKDHS Appendix C-1, Schedule VIII.) These individuals remain eligible for Medicaid benefits.

(4) **SSP eligible.** If a categorically needy applicant for Medicaid is also eligible for a State Supplemental Payment, the certification includes both Medicaid and the state payment.

(5) **Potentially Qualified Medicare Beneficiary Plus eligible.** The individual determined as categorically needy is also potentially eligible as a Qualified Medicare Beneficiary Plus (QMBP) (refer to subsection (b) of this Section). A determination is done to decide if income and resources are within standards on OKDHS Appendix C-1, Schedule VI., in which the income standards are based on 100% of the Federal Poverty Level. If the individual exercises the option of choosing QMBP coverage only, he/she is not certified to receive the State Supplemental Payment.

(b) **Income and resources at or above the SSP standard.** Individuals whose income and resources are at or above the SSP standard but less than the standards on OKDHS Appendix C-1, Schedule VI. are considered categorically needy.

317:35-10-38. Temporary absence from the home.

An individual who is temporarily absent from the home for the purpose of receiving training or education for employment, certain medical services, etc., may be considered part of the benefit group.

(1) Individuals temporarily absent from the home, receiving training or education for employment are considered part of the benefit group during the period of time the training or educational activities are taking place.

(2) Children temporarily absent from the home to attend boarding school are considered part of the benefit group during the school term.

(3) Individuals temporarily absent from the home because of entrance into a private facility for counseling, rehabilitation, behavioral problems or special training, etc., are considered part of the benefit group. If care is projected for a period exceeding 90 days, the absence is not considered temporary. At any time an absence is determined as not temporary or no longer temporary, the needs of the individual cannot be included in the benefit group.

(4) Individuals temporarily absent from the home for medical services, other than institutionalization for treatment of mental illness, mental retardation, or tuberculosis, are considered part of the benefit group for up to six months. Six-month extensions may be allowed when the worker's verification indicates the individual may return to the home within the next six months.