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POLICY TRANSMITTAL NO. 06-47	DATE: NOVEMBER 1, 2006
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS & POLICY

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TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-3-65.4; 30-5-13; 30-5-25; 30-5-391 through 30-5-393;  
30-5-676; 30-5-763; 30-5-764; and 30-5-951 through 30-5-953.

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

SoonerCare rules are revised to:

- (1) remove the prior authorization requirement for initial speech and hearing services for children. Currently, rules state that all speech and hearing services, including the initial evaluation, for children must be prior authorized by the agency's Medical Authorization Unit. All requests for an evaluation are routinely approved which creates a large volume of unnecessary work for the unit. Revisions allow reimbursement for the initial therapy evaluation and the first three speech and hearing visits without prior authorization;
- (2) add post-payment retrospective reviews of medical necessity for outpatient observation services;
- (3) shift the responsibility for the completion of the skilled nursing assessment and service planning from state employed OKDHS registered nurses to provider agency nurses for personal care services;
- (4) to establish a three-tier system in Agency Skilled and Registered Nursing Services to provide skilled nursing services to individuals demonstrating targeted medical needs enrolled in the Developmental Disabilities Services Division (DDSD) Homeward Bound and Community Waivers;
- (5) clarify the reimbursement guidelines for rape and abuse exams; and
- (6) add EPSDT coverage of environmental inspection service for children with elevated blood lead levels.

Original signed on 10-24-06

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Mary Stalnaker, Director  
Family Support Services Division

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Sharon Neuwald, Coordinator  
Office of Legislative Relations and Policy

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## **INSTRUCTIONS FOR FILING MANUAL MATERIAL**

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following 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) 521-6392.

### **REMOVE**

### **INSERT**

317:30-3-65.4	317:30-3-65.4, pages 1-4, revised 8-2-06
317:30-5-13	317:30-5-13, 1 page only, revised 8-2-06
317:30-5-25	317:30-5-25, pages 1-2, revised 8-2-06
317:30-5-391	317:30-5-391, 1 page only, revised 8-2-06
317:30-5-392	317:30-5-392, pages 1-4, revised 8-2-06
317:30-5-393	317:30-5-393, 1 page only, revised 8-2-06
317:30-5-676	317:30-5-676, 1 page only, revised 8-2-06
317:30-5-763	317:30-5-763, pages 1-21, revised 8-2-06
317:30-5-764	317:30-5-764, pages 1-4, revised 8-2-06
317:30-5-951	317:30-5-951, pages 1-2, revised 8-2-06
317:30-5-952	317:30-5-952, 1 page only, revised 8-2-06
317:30-5-953	317:30-5-953, 1 page only, revised 8-2-06

**317:30-3-65.4. Screening components**

Comprehensive EPSDT screenings are performed by, or under the supervision of, a SoonerCare physician. SoonerCare physicians are defined as all licensed medical and osteopathic physicians, physician assistants and advanced practice nurses in accordance with the rules and regulations covering the OHCA's medical care program. At a minimum, screening examinations must include, but not be limited to, the following components:

(1) **Comprehensive health and developmental history.** Health and developmental history information may be obtained from the parent or other responsible adult who is familiar with the child's history and include an assessment of both physical and mental health development. Coupled with the physical examination, this includes:

(A) **Developmental assessment.** Developmental assessment includes a range of activities to determine whether an individual's developmental processes fall within a normal range of achievement according to age group and cultural background. Screening for development assessment is a part of every routine, initial and periodic screening examination. Acquire information on the child's usual functioning as reported by the child, teacher, health professional or other familiar person. Review developmental progress as a component of overall health and well-being given the child's age and culture. As appropriate, assess the following elements:

- (i) Gross and fine motor development;
- (ii) Communication skills, language and speech development;
- (iii) Self-help, self-care skills;
- (iv) Social-emotional development;
- (v) Cognitive skills;
- (vi) Visual-motor skills;

- (vii) Learning disabilities;
- (viii) Psychological/psychiatric problems;
- (ix) Peer relations; and
- (x) Vocational skills.

(B) **Assessment of nutritional status.** Nutritional assessment may include preventive treatment and follow-up services including dietary counseling and nutrition education if appropriate. This is accomplished in the basic examination through:

- (i) Questions about dietary practices;
- (ii) Complete physical examination, including an oral dental examination;
- (iii) Height and weight measurements;
- (iv) Laboratory test for iron deficiency; and
- (v) Serum cholesterol screening, if feasible and appropriate.

(2) **Comprehensive unclothed physical examination.** Comprehensive unclothed physical examination includes the following:

(A) **Physical growth.** Record and compare height and weight with those considered normal for that age. Record head circumference for children under one year of age. Report height and weight over time on a graphic recording sheet.

(B) **Unclothed physical inspection.** Check the general appearance of the child to determine overall health status and detect obvious physical defects. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal.

(3) **Immunizations.** Legislation created the Vaccine for Children Program to be effective October 1, 1994. Vaccines will be provided free of charge to all enrolled providers for Medicaid

eligible children. Participating providers may bill for an administration fee to be set by CMS, formerly known as HCFA on a regional basis. They may not refuse to immunize based on inability to pay the administration fee.

(4) **Appropriate laboratory tests.** A blood lead screening test (by either finger stick or venipuncture) must be performed between the ages of nine and 12 months and at 24 months. A blood lead test is required for any child up to age 72 months who had not been previously screened. A blood lead test equal to or greater than 10 micrograms per deciliter (ug/dL) obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. If a child is found to have blood lead levels equal to or greater than 10 ug/dL, the Oklahoma Childhood Lead Poison Prevention Program (OCLPPP) must be notified according to rules set forth by the Oklahoma State Board of Health (OAC 310:512-3-5).

(A) The OCLPPP schedules an environmental inspection to identify the source of the lead for children who have a persistent blood lead level 15 ug/dL or greater. Environmental inspections are provided through the Oklahoma State Department of Health (OSDH) upon notification from laboratories or providers and reimbursed through the OSDH cost allocation plan approved by OHCA.

(B) Medical judgment is used in determining the applicability of all other laboratory tests or analyses to be performed unless otherwise indicated on the periodicity schedule. If any laboratory tests or analyses are medically contraindicated at the time of the screening, they are provided when no longer medically contraindicated. Laboratory tests should only be given when medical judgment determines they are appropriate. However, laboratory tests should not be routinely administered. General procedures including immunizations and lab tests, such as blood lead, are outlined in the periodicity schedule found at OAC 317:30-3-65.2.

(5) **Health education.** Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental assessment, or screening, gives the initial context for providing health education. Health education and counseling to parents, guardians or

children is required. It is designed to assist in understanding expectations of the child's development and provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

(6) **Vision and hearing screens.** Vision and hearing services are subject to their own periodicity schedules. However, age-appropriate vision and hearing assessments may be performed as a part of the screening as outlined in the periodicity schedule found at OAC 317:30-3-65.7 and 317:30-3-65.9.

(7) **Dental screening services.** An oral dental examination may be included in the screening and as a part of the nutritional status assessment. Federal regulations require a direct dental referral for every child in accordance with the periodicity schedule and at other intervals as medically necessary. Therefore, when an oral examination is done at the time of the screening, the child may be referred directly to a dentist for further screening and/or treatment. Specific dental services are outlined in OAC 317:30-3-65.8.

(8) **Child abuse.** Instances of child abuse and/or neglect discovered through screenings and regular examinations are to be reported in accordance with State Law. Title 21, Oklahoma Statutes, Section 846, as amended, states in part: "Every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic physicians, residents, and interns, examining, attending, or treating a child under the age of 18 years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of 18 years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above". Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought solely as a result of the filing of the report.

317:30-5-13. Rape and abuse exams

When a rape/abuse exam is performed on a child with SoonerCare benefits, a claim is filed with the fiscal agent. Payment is made for the rape/abuse exam and medically necessary procedures as per recognized coding guidelines.

(1) Supplies used during an exam for rape or abuse may be billed. Appropriate HCPCS and diagnosis codes are used.

(2) If the child is in custody as reported by the Oklahoma Department of Human Services but does not have SoonerCare benefits, or the child is not in custody and the parents are unable or unwilling to assume payment responsibility, the social worker obtains from the physician a completed OKDHS form 10AD012, Claim Form. The 10AD012 form is routed according to procedures established by the Oklahoma Department of Human Services, Division of Children and Family Services.



**317:30-5-25. Oklahoma Health Care Authority's Quality Improvement Organization (QIO)**

All inpatient stays and outpatient observation services are subject to post-payment utilization review by the OHCA's designated Quality Improvement Organization (QIO). These reviews are based on severity of illness and intensity of treatment.

(1) It is the policy and intent of OHCA to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay or outpatient observation of a SoonerCare member. If the QIO, upon their initial review determines the admission or outpatient observation services should be denied, a notice is issued to the facility and the attending physician advising them of the decision. This notice also advises that a reconsideration request may be submitted within the specified timeframe on the notice and consistent with the Medicare guidelines. Additional information submitted with the reconsideration request is reviewed by the QIO that utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, the QIO sends written notification of the denial decision to the hospital, attending physician and the OHCA. Once the OHCA has been notified, the overpayment is processed as per the final denial determination.

(2) If the hospital or attending physician did not request reconsideration from the QIO, the QIO informs OHCA there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, processes the overpayment as per the denial notice sent to the OHCA by the QIO.

(3) If the QIO's review results in denial and the denial is upheld throughout the review process and refund from the hospital and physician is required, the SoonerCare member cannot be billed for the denied services.

(4) If a hospital or physician believes a hospital admission, continued stay, or outpatient observation service is not medically necessary and thus not SoonerCare compensable but the member insists on treatment, the member is informed that he/she will be personally responsible for all charges.

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**OAC 317:30-5-25 (p2)**

(A) If a SoonerCare claim is filed and paid and the service is later denied after medical necessity review, the member is not responsible.

(B) If a SoonerCare claim is not filed, the member can be billed.

**317-30-5-391. Coverage for Skilled Nursing Services**

(a) All Skilled Nursing Services must be ordered and prescribed by a physician, supported by a nursing plan of care, included in the individual plan as described in OAC 340:100-5-53 and reflected in the Plan of Care approved in accordance with OAC 340:100-3-33 and OAC 340:100-3-33.1. For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, physician assistants and advanced practice nurses in accordance with the rules and regulations covering the OHCA's medical care program. Arrangements for waiver Skilled Nursing Services are made through the personal support team with the specific involvement of the assigned Developmental Disabilities Services Division (DDSD) registered nurse (RN). The DDSD RN develops a nursing service support plan subject to review and authorization by the DDSD state nursing director or designee.

(b) Skilled Nursing Services are rendered in such a manner as to provide the service recipient as much autonomy as possible.

(1) Skilled Nursing Services must be flexible and responsive to changes in the service recipient's needs.

(2) Providers are expected to participate in annual personal support team meetings and other team meetings as required.

(3) Appropriate supervision of Skilled Nursing Services including services provided by licensed practical nurses (LPNs) is provided pursuant to State law and regulatory board requirements.

(4) Individual service providers must be RNs or LPNs currently licensed to practice in the State of Oklahoma.



317:30-5-392. Description of Skilled Nursing services

Types of Skilled Nursing Services in the waiver programs offered by the Oklahoma Department of Human Services' Developmental Disabilities Services Division (DDSD) are:

(1) **Extended Duty Skilled Nursing Care.** Extended Duty Skilled Nursing Care allows a licensed nurse to provide direct services in a community setting up to 24 hours per day.

(A) Extended Duty Skilled Nursing Care must be:

(i) provided only to those service recipients who have health-related issues that require skilled treatment or other intervention by a licensed nurse more frequently than every two hours;

(ii) ordered by a licensed medical physician, osteopathic physician, physician assistant, or advanced practice nurse;

(iii) justified in amount by the review done in accordance with OAC 340:100-5-26; and

(iv) documented in the service recipient's Plan of Care.

(B) When Extended Duty Skilled Nursing Care is medically indicated in accordance with subparagraph (A) of this paragraph, Extended Duty Skilled Nursing Care includes:

(i) skilled nursing care and interventions rendered directly to the service recipient by the nurse;

(ii) monitoring, evaluation, and documentation of the service recipient's physical or mental status;

(iii) administration of medication or treatments or both as ordered by the licensed medical physician, osteopathic physician, physician assistant or advanced practice nurse;

(iv) documentation of medication or treatment administration, skilled nursing interventions, service recipients's responses to medication or treatment, and any adverse reactions, or other significant changes;

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(v) implementation of all tasks and objectives of the written nursing plan of care; and

(vi) performance of training and general care to the service recipient during periods in which skilled nursing tasks and interventions are not being performed.

(2) Intermittent Skilled Nursing Care. Intermittent Skilled Nursing Care involves performance of intermittent skilled tasks or interventions that only a licensed nurse can perform according to Section 1020 of Title 57 of the Oklahoma Statutes and OAC 340:100-5-26.3.

(A) Intermittent Skilled Nursing Care must be:

(i) ordered by a licensed medical physician, osteopathic physician, physician assistant or advanced practice nurse;

(ii) justified in amount by the review done in accordance with OAC 340:100-5-26; and

(iii) documented in the service recipient's Plan of Care.

(B) Intermittent Skilled Nursing Care includes:

(i) skilled nursing care and interventions rendered directly to the service recipient, as ordered by the licensed medical physician, osteopathic physician, physician assistant, or advanced practice nurse;

(ii) health-related assessments;

(iii) administration of medication or treatments ordered by the licensed medical physician, osteopathic physician, physician assistant, or advanced practice nurse;

(iv) documentation of medication or treatment administration, the service recipient's response to medication or treatment, and any adverse reaction or other significant changes; and

(v) implementation of all tasks and objectives of the

nursing plan of care.

**(3) Individualized Skilled Nurse Training and Evaluation.**  
Individualized Skilled Nurse Training and Evaluation provides individualized evaluation and oversight of health care needs by a licensed nurse and specific, individualized health training by a licensed nurse to the service recipient or the service recipient's family or paid caregivers in accordance with Section 1020 of Title 56 of the Oklahoma Statutes and OAC 340:100-5-26.3.

(A) The licensed nurse assesses the service recipient's training needs prior to initiating competency-based training and develops a nursing plan of care that outlines the methods, goals, and objectives of the training to be performed. The nurse exercises prudent judgment in making the final decision as to what may be trained and delegated to community service workers, as provided by Section 1020 of Title 56 of the Oklahoma Statutes.

(B) Services include:

(i) individualized nurse training or evaluation or both provided directly to the service recipient, family or paid caregiver(s), as identified in the individual plan and the nursing plan of care;

(ii) evaluation and documentation of the competency of individuals trained through return demonstration, written test, verbalization of understanding, or other means suitable to the type of training performed;

(iii) professional monitoring and supervision to the community service worker in accordance with the applicable licensing requirements and evaluation of:

(I) the stability of the condition of the service recipient;

(II) the training and capability of the person receiving training;

(III) the nature of the task being trained; and

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**OAC 317:30-5-392 p(4)**

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(IV) the proximity and availability of the licensed nurse to the person when the task is being performed; and

(iv) attendance at required meetings as specified in the individual plan.

**317:30-5-393. Coverage limitations for Skilled Nursing Services**

(a) Extended Duty Skilled Nursing Care cannot exceed three eight-hour shifts in a 24-hour period.

(b) Intermittent Skilled Nursing Care is limited to no more than three skilled task site visits in a 24-hour period of time.

(c) Individualized Skilled Nurse Training and Evaluation is reimbursed on the basis of a 15-minute unit of service. No more than 16 units of Individualized Skilled Nurse Training and Evaluation can be provided per month, unless the exception is:

(1) justified in writing by the team in accordance with OAC 340:100-3-33.1;

(2) recommended by the DDSD area nurse manager; and

(3) meets the requirements of OAC 340:100-3-33.1.



**317:30-5-676. Coverage by category**

Payment is made for speech and hearing services as set forth in this Section.

(1) **Children.** Coverage for children is as follows:

(A) **Preauthorization required.** Initial therapy evaluations and the first three therapy visits do not require prior authorization. All therapy services following the initial evaluation and first three visits must be preauthorized prior to continuation of service.

(B) **Speech/Language Services.** Speech/language therapy services may include speech/language evaluations, individual and group therapy services provided by a state licensed speech/language pathologist.

(C) **Hearing aids.** Hearing and hearing aid evaluations include pure tone air, bone and speech audiometry by a state licensed audiologist. Payment is made for a hearing aid following a recommendation by a Medical or Osteopathic physician and a hearing aid evaluation by a state licensed audiologist.

(2) **Adults.** There is no coverage for adults.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.



**317:30-5-763. Description of services**

Services included in the ADvantage Program are as follows:

**(1) Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety.

Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), Case Managers are required to receive training and demonstrate knowledge regarding CD-PASS service delivery model, "Independent Living Philosophy" and demonstrate competency in Person-centered planning.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training or authority, can perform on behalf of a member;

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(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

(C) Case Management services are prior authorized and billed per 15-minute unit of service using the rate associated with the location of residence of the member served.

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in AA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.

(iii) The United States 2000 Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

**(2) Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be

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utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the plan of care.

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

(D) In-Home Extended Respite is filed for a per diem rate. A minimum of eight hours must be provided in the member's home.

**(3) Adult Day Health Care.**

(A) Adult Day Health Care is furnished on a regularly scheduled basis for one or more days per week, at least four hours per day in an outpatient setting. It provides both health and social services which are necessary to ensure the optimal functioning of the member. Physical, occupational, respiratory and/or speech therapies may only be provided as an enhancement to the basic Adult Day Health Care service when authorized by the plan of care and billed as a separate procedure. Meals provided as part of this service shall not constitute a full nutritional regimen. Transportation between the member's residence and the service setting is provided as a part of Adult Day Health Care. Personal Care service enhancement in Adult Day Health Care is assistance in bathing and/or hair washing authorized by the plan of care and billed as a separate procedure. Most assistance with activities of daily living, such as eating, mobility, toileting and nail care, are services that are integral to the Adult Day Health Care service and are covered by the Adult Day Health Care basic reimbursement rate. Assistance with bathing and/or hair care is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing and/or hair washing will be authorized when an ADvantage waiver member who uses adult day health care requires assistance with

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bathing and/or hair washing to maintain health and safety.

(B) Adult Day Health Care is a 15 minute unit. No more than 6 hours are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved plan of care.

(C) Adult Day Health Care Therapy Enhancement is a maximum one session per day unit of service.

(D) Adult Day Health Personal Care Enhancement is a maximum one per day unit of bathing and/or hair washing service.

**(4) Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

**(5) Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service shall exclude any equipment and/or supply items which are not of direct medical or remedial benefit to the waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. All services must be prior authorized.

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(6) **Comprehensive Home Care.** Comprehensive Home Care is an integrated service-delivery package which includes case management, personal care, skilled nursing, in-home respite and advanced supportive/restorative assistance.

(A) Comprehensive Home Care is provided by an agency which has been trained and certified by the Long Term Care Authority to provide an integrated service delivery system. Comprehensive Home Care is case management in combination with one or more of the following services:

- (i) personal care,
- (ii) in-home respite,
- (iii) skilled nursing, and/or
- (iv) advanced supportive/restorative services.

(B) All services must be provided in the home and must be sufficient to achieve, maintain or improve the member's ability to carry out daily living activities. However, with OKDHS area nurse approval, or for ADvantage waiver members, with service plan authorization and ADvantage Program Manager approval, Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified on the service plan. The sub-component services of Comprehensive Home Care are the same as described in (A) of this paragraph (see subparagraph (1)(A) of this section for Case Management services, OAC 317:35-15-2 for Personal Care service, subparagraph (8)(A) of this section for Skilled Nursing, subparagraph (2)(A) of this section for In-Home Respite, and subparagraph (7)(A) of this section for Advanced Supportive/Restorative Assistance).

(C) CHC services are billed using the appropriate HCPC procedure code along with the CHC provider location code on the claim.

(7) **Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic,

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yet stable, condition. The service assists with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

**(8) Skilled Nursing.**

(A) Skilled Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to be treatment for an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide, assessment of the member's health and assessment of services to meet the member's needs as specified in the plan of care.

A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member. An assessment/evaluation visit report will be made to the ADvantage Program case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The ADvantage Program case manager may recommend authorization of Skilled Nursing services for participation in interdisciplinary team planning of service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced

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supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the ADvantage Program case manager may recommend authorization of Skilled Nursing services for the following:

(I) filling a one-week supply of insulin syringes for a blind diabetic who can self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) setting up oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk of skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological deficiency;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the chronic condition. Provide skills training (including return skills demonstration to establish competency) for preventive and rehabilitative care procedures to the member, family and/or other informal caregivers as specified in the service plan.

(B) Skilled Nursing service is billed for service plan development and/or assessment/evaluation services or, for non-assessment services. Skilled Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure code is used to bill for all other authorized skilled nursing

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services. A minimum of three and a maximum of seven units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to produce a nurse evaluation is an agreement, as well, to provide the nurse assessment identified Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation shall be denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified Medicaid in-home care services for which the provider is certified and contracted.

**(9) Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day brought to the member's home. Each meal has a nutritional content equal to one third of the Recommended Daily Allowance. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal/unit. The limit of the number of units a member is allowed to receive is limited on the member's plan of care.

**(10) Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services,

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where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

**(11) Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

**(12) Comprehensive Home Care (CHC) Personal Care.**

(A) Comprehensive Home Care (CHC) Personal Care is assistance to a member in carrying out activities of daily living such

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as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the member or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) CHC Case Manager and Skilled Nursing staff are responsible for development and monitoring of the member's CHC Personal Care plan.

(C) Comprehensive Home Care (CHC) Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the Advantage approved plan of care.

**(13) Speech and Language Therapy Services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed speech/language therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute

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unit of service. Payment is not allowed solely for written reports or record documentation.

**(14) Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involved use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Respiratory Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

**(15) Hospice Services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member 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 member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical

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team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. ADvantage Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for ADvantage Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

(B) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the Hospice provider is responsible for providing Hospice services as needed by the member or member's family.

**(16) ADvantage Personal Care.**

(A) ADvantage Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) ADvantage Home Care Agency Skilled Nursing staff working in coordination with an ADvantage Case Manager are

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responsible for development and monitoring of the member's Personal Care plan.

(C) ADvantage Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the ADvantage approved plan of care.

**(17) Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency.

The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For an ADvantage Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

(i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) demonstrates capability to comprehend the purpose of and activate the PERS;

(iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

(v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,

(vi) the service avoids premature or unnecessary institutionalization of the member.

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(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the ADvantage approved plan of care.

**(18) Consumer-Directed Personal Assistance Services and Support (CD-PASS).**

(A) Consumer-Directed Personal Assistance Services and Supports are Personal Services Assistance, Advanced Personal Services Assistance and Employer Support Services that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self care, and mobility. CD-PASS services are delivered as authorized on the service plan. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Employer Support Services provider, for ensuring that the employment complies with State and Federal Labor Law requirements. The member may designate an adult family member or friend, an individual who is not a PSA or APSA to the member, as an Authorized representative@ to assist in executing these employer functions. The member:

(i) recruits, hires and, as necessary, discharges the PSA or APSA;

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Consumer Directed Agent/Case Manager to obtain ADvantage skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the SPSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASPA's personnel file;

(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;

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(iv) supervises and documents employee work time; and,

(v) provides tools and materials for work to be accomplished.

(B) The service Personal Services Assistance may include:

(i) assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both;

(ii) assistance with routine bodily functions that may include:

(I) bathing and personal hygiene;

(II) dressing and grooming;

(III) eating including meal preparation and cleanup;

(iii) assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores;

(iv) companion type assistance that may include letter writing, reading mail and providing escort or transportation to participate in approved activities or events. "Approved activities or events" means community civic participation guaranteed to all citizens including but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member that may include shopping for food, clothing or other necessities, or for participation in other activities or events that are specifically approved on the service plan.

(C) Advanced Personal Services Assistance are maintenance services provided to assist a member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used

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as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their attending physician who may, if appropriate, order home health services. The service of Advanced Personal Services Assistance includes assistance with health maintenance activities that may include:

(i) routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies with well-healed stoma) and external, in dwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;

(ii) remove external catheters, inspect skin and reapplication of same;

(iii) administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (Pre-packaged only) with members without contraindicating rectal or intestinal conditions;

(iv) apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;

(v) use lift for transfers;

(vi) manually assist with oral medications;

(vii) provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;

(viii) apply non-sterile dressings to superficial skin breaks or abrasions; and

(ix) use Universal precautions as defined by the Center for Disease Control.

(D) The service Employer Support Services is assistance with employer related cognitive tasks, decision-making and specialized skills that may include:

(i) assistance with Individual Budget Allocation planning

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and support for making decisions, including training, reference material and consultation, regarding employee management tasks such as recruiting, hiring, training and supervising the Personal Service Assistant or Advanced Personal Service Assistant;

(ii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;

(iii) for making available Hepatitis B vaccine and vaccination series to PSA and APSA employees in compliance with OSHA standards;

(iv) for performing Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(I) employer payroll, at a minimum of semi monthly, and associated mandatory withholding for taxes, Unemployment Insurance and Workers' Compensation Insurance performed on behalf of the member as employer of the PSA or APSA; and

(II) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation.

(E) The service of Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the Service Plan.

(F) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the Service Plan.

(G) The service of Employer Support Services is billed per month unit of service. The Level of service and number of units of Employer Support Services a member may receive is limited to the Level and number of units approved on the Service Plan.

**(19) Institution Transition Services.**

(A) Institution Transition Services are those services that are necessary to enable an individual to leave the institution and receive necessary support through ADvantage waiver services in their home and/or in the community. Institution Transition Services may include, as necessary, any one or a combination of the following:

(i) Case Management;

(ii) Nursing Assessment and Evaluation for in-home service planning;

(iii) Environmental Modifications including Assessment for Transition Environmental Modification Services; and/or,

(iv) Medical Equipment and Supplies.

(B) Institution Transition Case Management Services are services as described in OAC 317:30-5-763(1) required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. ADvantage Transition Case Management Services assist institutionalized individuals that are eligible to receive ADvantage services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transition Case Management Services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the service plan, including necessary Institution Transition Services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transition Case Management Services may be authorized to assist individuals that have not previously received ADvantage services but have been referred by the AA or OKDHS to the Case Management Provider for assistance in transitioning from the institution to the community with ADvantage services support.

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(i) Institution Transition Case Management services are prior authorized and billed per 15 minute unit of service using the appropriate HCPC and modifier associated with the location of residence of the member served as described in OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish Institution Transition Case Management services from regular Case Management services.

(C) Institution Transition Skilled Nursing Services are nursing services, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. Institutional Transition Skilled Nursing services are solely for assessment/evaluation and service planning for in-home assistance services.

(i) Institution Transition Skilled Nursing services are prior authorized and billed per assessment/evaluation visit using the appropriate HCPC.

(ii) A unique modifier code is used to distinguish Institution Transition Skilled Nursing Services from regular Skilled Nursing Services.

(D) Institution Transition Environmental Modifications are those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. Such adaptations are the same as described under OAC 317:30-5-763(4)(A) and may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial

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benefit to the individual, such as carpeting, roof repair central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes. Services may include accessibility evaluation of the member's home and follow-up evaluation of the adequacy of installed environmental modifications to meet the member's accessibility and environmental adaptive needs. Accessibility evaluation services must be performed by an Accessibility Specialist who is trained and certified through a Federal or State agency approved program for Americans with Disabilities Act (ADA) Accessibility Guidelines - Title III (Public Accommodations) or by a physical or occupational therapist. Accessibility evaluation services do not include evaluations of the need for modifications or equipment that serve a therapeutic or rehabilitative function for which a therapist evaluation is necessary.

(i) Institution Transition Environmental Modification services are prior authorized and billed using the appropriate HCPC.

(ii) A unique modifier code is used to distinguish Institution Transition Environmental Modification Services and Assessments from regular Environmental Modification Services and Assessments.

(E) Institution Transition Specialized medical equipment and supplies are those devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Item reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude

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**OAC 317:30-5-763 p(21)**

those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

(i) Institution Transition Medical Equipment and Supply services are prior authorized and billed using the appropriate HCPC.

(ii) A unique modifier code is used to distinguish Institution Transition Medical Equipment and Supply Services from regular Medical Equipment and Supply services.

(F) Institutional Transition Services may be authorized and reimbursed under the following conditions:

(i) The service is necessary to enable the individual to move from the institution to their home;

(ii) The individual is eligible to receive ADvantage services outside the institutional setting;

(iii) Institutional Transition Services are provided to the individual within 120 days of discharge from the institution;

(iv) Transition Services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(G) If the member has received Institution Transition Services but fails to enter the waiver, any Institution Transition Services authorized and provided are reimbursed as "Medicaid administrative" costs and providers follow special procedures specified by the AA to bill for services provided.



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**317:30-5-764. Reimbursement**

(a) Rates for waiver services are set in accordance with the rate setting process by the Committee for Rates and Standards and approved by the Oklahoma Health Care Authority Board.

(1) The rate for NF Respite is set equivalent to the rate for enhanced nursing facility services that require providers having equivalent qualifications;

(2) The rate for daily units for Adult Day Health Care are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Adult Day Service Program that require providers having equivalent qualifications;

(3) The rate for units of Home-Delivered Meals are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Home-Delivered Meals Program that require providers having equivalent qualifications;

(4) The rates for units of In-Home Respite, CHC Personal Care, and CHC In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate which require providers having equivalent qualifications;

(5) The rates for a unit of Skilled Nursing and CHC Skilled Nursing are set equivalent to the Advantage Case Management Standard rate.

(6) CD-PASS rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(A) Authorized PSA and APSA units (determined from CDA/CM and member planning);

(B) Total CD-PASS IBA (annualized authorized units X the rate for comparable agency personal assistance services). The Total CD-PASS IBA (TIBA) is the annualized budget amount calculated to cover reimbursement for all CD-PASS services - Personal Services Assistance (PSA), Advanced Personal

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Services Assistance (APSA) and Employer Support Services (ESS). The TIBA is equal to that portion of the annualized cost for Personal Care services and Advanced Supportive/Restorative assistance under the member's existing service plan that CD-PASS services replace;

(C) Authorized Employer Support Service level (based on AA assessment of member's level of need for Employer Supportive Services from review of Consumer Readiness assessment for those new to CD-PASS or performance if existing CD-PASS participant);

(D) Total Annual ESS budget allocation (annualized ESS authorized units X the ESS level rate) and

(E) Client IBA (CIBA) which is equal to the Total CD-PASS IBA minus Total ESS allocation (E=B-D).

(F) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS to be equal to or less than expenditures for equivalent services using agency providers.

The TIBA and service unit rates are calculated by the AA during the CD-PASS service eligibility determination process.

Based upon the member record review, member "Self-assessment of Readiness" to assume employer role and responsibilities and other available information, the AA authorizes a level of support to cover Employer Support Service needs. This process establishes the monthly rate for Employer Support Services. Thereafter, as part of the service planning authorization process at a minimum of annually, the AA, in consultation with the member reviews and updates the authorized level of Employer Support Services.

(G) The PSA rate is determined as follows. The monthly ESS rate amount is subtracted from an amount equivalent to the total monthly unit authorization reimbursement for agency Personal Care (PC) services under the member's existing service plan and the result is divided by the total number of PC units authorized per month.

(i) The allocation of portions of PSA rate to cover salary, mandatory taxes, Worker's Compensation insurance and optional benefits is determined individually for each

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**OAC 317:30-5-764 p(3)**

member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process;

(ii) If both APSA and PSA units are being authorized the ESS monthly rate amount employed in the PSA rate determination is in proportion to the units of PSA to combined PSA plus APSA units;

(H) The APSA rate is determined as follows. The monthly ESS rate amount is subtracted from an amount equivalent to the total monthly unit authorization reimbursement for agency Advanced Supportive/Restorative (ASR) assistance services under the member's existing service plan and the result divided by the total number of ASR units authorized per month.

(i) The allocation of portions of APSA rate to cover salary, mandatory taxes, Worker's Compensation insurance and optional benefits is determined individually for each member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process;

(ii) If both APSA and PSA units are being authorized, the ESS monthly rate amount employed in the APSA rate determination is in proportion to the units of APSA to combined PSA plus APSA units.

(I) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for CD-PASS services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the Case Manager, based upon an updated assessment, amends the service plan to increase CD-PASS service units appropriate to meet additional member need. The AA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the ESSP, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(b) The AA approved ADvantage service plan is the basis for the

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MMIS service prior authorization, specifying:

- (1) service;
- (2) service provider;
- (3) units authorized; and
- (4) begin and end dates of service authorization.

(c) As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to SURS for follow-up investigation.

**317:30-5-951. Coverage by category**

SoonerCare payment is made to agencies, on behalf of SoonerCare members, for personal care services (PC services) provided in the member's home. Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified on an approved care plan. Personal care services prevent or minimize a member's physical health regression and deterioration. Tasks performed during the provision of PC services include, but are not limited to, assisting an individual in performing tasks of personal hygiene, dressing and medication. Tasks may also include meal preparation, light housekeeping, errands, and laundry directly related to the recipient's personal care needs. Personal care does not include the provision of care of a technical nature. For example, tracheal suctioning, bladder catheterization, colostomy irrigation and operation/maintenance of technical machinery is not performed as part of PC services. PC skilled nursing service is an assessment of the member's needs to determine the frequency of PC services and tasks performed, development of a PC service care plan to meet identified personal care needs, service delivery oversight and annual re-assessment and updating of care plan. It may also include more frequent re-assessment and updating of the care plan if changes in the member's needs require.

(1) **Adults.** Payment for services provided by a PC services agency is made on behalf of eligible individuals who have needs requiring the service in accordance with OAC 317:35-15-4 as determined through an assessment utilizing the Uniform Comprehensive Assessment Tool (UCAT). Before PC services can begin the individual must:

(A) require a care plan involving the planning and administration of services delivered under the supervision of professional personnel;

(B) have a physical impairment or combination of physical and mental impairments;

(C) lack the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and

(D) require assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration.

(2) **Children.** Coverage for persons under 21 years of age is the same as for adults.

**317:30-5-952. Prior authorization**

Eligible members receiving personal care services must have an approved care plan developed by a PC services skilled nurse. For persons receiving ADvantage Program services, the nurse works with the member's ADvantage Program Case Manager to develop the care plan. The amount and frequency of the service, to be provided to the member, is listed on the care plan. The amount and frequency of PC services is approved by the OKDHS nurse or by the Administrative Agent's (AA) authorization of the ADvantage Program Service Plan. At the time of a PC services member's initial referral to a PC services agency, OKDHS or AA authorizes PC services, skilled nursing for PC services, needs assessment and care plan development. The number of units of PC services or PC skilled nursing the member is eligible to receive is limited to the amounts approved on the care plan as authorized by OKDHS or AA. Care plans are authorized for no more than one year from the date of care plan authorization. Services provided without prior authorization are not compensable.



**317:30-5-953. Billing**

A billing unit of service for personal care skilled nursing service equals a visit. A billing unit of service for personal care services provided by a PC service agency is 15 minutes of PC services delivery. Billing procedures for Personal Care services are contained in the OKMMIS Billing and Procedure Manual.