TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-3-19; 30-3-20; 30-3-21; 30-5-25; 30-5-41; 30-5-47; 30-5-62; 30-5-95.2; 30-5-123; 30-5-124; 30-5-131.1; 30-5-131.2; 30-5-241; 30-5-327; 30-5-412; 30-5-586.1; 30-5-596.1; 30-5-746; 40-7-2; and 40-7-12.

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

Hospital rules are revised to reinstate language related to pre-admission procedures that were inadvertently deleted from rules. Appeal rules are revised to accurately reflect the agency hearing various appeals. Other revisions (a) relocate the appeal procedures to appropriate sections of rules to help clarify the correct procedures to be followed, and (b) correct various rule references.

Developmental Disabilities Services Division Family Support Services rules are revised to increase the annual limits on expenditures for Individual and Group Family Training Services from $5000 to $5500 per service recipient.

DDSD rules are revised to implement a rate increase appropriated by the Legislature for waiver employment services for persons with mental retardation. Rates will be increased for services to persons in individual placements who receive job coach services or community-based services. Also, the definition of an individual placement is established in the rules.

Original signed on 6-23-06

James M. Nicholson, Director
Developmental Disabilities Services Division

Sharon Neuwald, Co-Interim Administrator
Office of Planning, Policy & Research

WF # 06-I (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.

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317:30-3-19. Administrative sanctions

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

(1) "**Abuse**" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also recognizes recipient practices that result in unnecessary cost to the Medicaid program.

(2) "**Conviction**" or "**Convicted**" means a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

(3) "**Exclusion**" means items or services which will not be reimbursed under Medicaid because they were furnished by a specific provider who has defrauded or abused the Medicaid program.

(4) "**Fraud**" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

(5) "**Knowingly**" means that a person, with respect to information:

   (A) has actual knowledge of the information;

   (B) acts in deliberate ignorance of the truth or falsity of the information; or

   (C) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

(6) "**Medical Services Providers**" means:

   (A) "**Practitioner**" means a physician or other individual licensed under State law to practice his or her profession or
a physician who meets all requirement for employment by the Federal Government as a physician and is employed by the Federal Government in an IHS facility or affiliated with a 638 Tribal facility.

(B) "Supplier" means an individual or entity, other than a provider or practitioner, who furnishes health care services under Medicaid or other medical services programs administered by the Oklahoma Health Care Authority.

(C) "Provider" means:

(i) A hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or a hospice that has in effect an agreement to participate in Medicaid, or any other medical services program administered by the Oklahoma Health Care Authority, or

(ii) a clinic, a rehabilitation agency, or a public health agency that has a similar agreement.

(D) "Laboratories" means any laboratory or place equipped for experimental study in science or for testing or analysis which has an agreement with the Oklahoma Health Care Authority to receive Medicaid monies.

(E) "Pharmacy" means any pharmacy or place where medicines are compounded or dispensed or any pharmacist who has an agreement with OHCA to receive Medicaid monies for the dispensing of drugs.

(F) "Any other provider" means any provider who has an agreement with OHCA to deliver health services, medicines, or medical services for the receipt of Medicaid monies.


(8) "Sanctions" means any administrative decision by OHCA to suspend or exclude a medical service provider(s) from the Medicaid program or any other medical services program administered by the Oklahoma Health Care Authority.

(9) "Suspension" means items or services furnished by a specified provider will not be reimbursed under the Medicaid program.
(10) "Willfully" means proceeding from a conscious motion of the will; voluntary, intending the result which comes to pass; intentional.

(b) Basis for sanctions.

(1) The Oklahoma Health Care Authority may sanction a medical provider who has an agreement with OHCA for the following reasons:

(A) Knowingly or willfully made or caused to be made any false statement or misrepresentation of material fact in making, or use in determining the right to, payment under Medicaid;

(B) Furnished or ordered services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized standards for health care;

(C) Submitted or caused to be submitted to the Medicaid program bills or requests for payment containing charges or costs that are substantially in excess of customary charges or costs. However, the agency must not impose an exclusion under this section if it finds the excess charges are justified by unusual circumstances or medical complications requiring additional time, effort, or expense in localities in which it is accepted medical practice to make an extra charge in such case.

(2) The agency may base its determination that services were excessive or of unacceptable quality on reports, including sanction reports, from any of the following sources:

(A) The PRO for the area served by the provider or the PRO contracted by OHCA;

(B) State or local licensing or certification authorities;

(C) Peer review committees of fiscal agents or contractors;

(D) State or local professional societies;

(E) Surveillance and Utilization Review Section Reports done by OHCA; or
(F) Other sources deemed appropriate by the Medicaid agency or the OIG.

(3) OHCA must suspend from the Medicaid program any medical services provider who has been suspended from participation in Medicare or Medicaid due to a conviction of a program related crime. This suspension must be at a minimum the same period as the Medicare suspension.

(4) OHCA must also suspend any convicted medical services provider who is not eligible to participate in Medicare or Medicaid whenever the OIG directs such action. Such suspension must be, at a minimum, the same period as the suspension by the OIG.

(c) **Procedure for imposing sanctions.** The procedure for imposing a sanction under this section and the due process accorded in this section is provided at OAC 317:2-1-5.
317:30-3-20. Appeals procedures (excluding nursing homes and hospitals)

OHCA has established administrative procedures whereby a medical provider may request a review of the decision of the amount paid or the non-payment of medical services provided an eligible recipient. If the medical provider does not agree with the original payment from the Fiscal Agent, he/she may submit a written explanation as to why the adjustment is being requested and what action is to be taken, a copy of the paid remittance statement and/or detailed explanation of the paid information and a copy of the original claim with the corrections to be made for consideration of additional payment. The claim should be filed in accordance with the instructions in the OAC 317:30-7 for the type of medical provider involved.
317:30-3-21. Appeals procedures for nursing facilities

Appeal procedures for denial, failure to renew, or termination of a nursing facility agreement are described at OAC 317:2-1-8. The Oklahoma State Department of Health, by agreement, continues to be responsible for hearings for licensure and certification as the survey agency.
317:30-5-25. Oklahoma Foundation for Medical Quality

All inpatient services are subject to post-payment utilization review by the Oklahoma Foundation for Medical Quality (OFMQ). These reviews will be based on severity of illness and intensity of treatment.

(1) It is the policy and intent 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 of a Medicaid recipient. If the OFMQ upon their initial review determines the admission should be denied, a notice is issued to the facility and the attending physician advising them of the decision. This notice also advises that a reconsideration request may be submitted in accordance with the Medicare time frame. Additional information submitted with the reconsideration request will be reviewed by the OFMQ who utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, OHCA is informed. At that point, OHCA sends a letter to the hospital and physician requesting refund of the Medicaid payment previously made on the denied admission.

(2) If the hospital or attending physician did not request reconsideration by the OFMQ, the OFMQ informs OHCA there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, sends a letter to the hospital and physician informing of recoupment of Medicaid payment previously made on the denied admission.

(3) If an OFMQ review results in denial and the denial is upheld throughout the review process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services.

(4) If a hospital or physician believes a hospital admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient insists on treatment, the patient should be informed that he/she will be personally responsible for all charges. If a Medicaid claim is filed and paid and the service is later denied the patient is not responsible. If a Medicaid claim is not filed the patient can be billed.
317:30-5-41. Coverage for adults

For persons 21 years of age or older, payment is made to hospitals for services as described in this Section.

(1) Inpatient hospital services.

(A) Effective August 1, 2000, all general inpatient hospital services for all persons 21 years of age or older is limited to 24 days per person per state fiscal year (July 1 through June 30). The 24 day limitation applies to both hospital and physician services. No exceptions or extensions will be made to the 24 day inpatient services limitation.

(B) Effective October 1, 2005, claims for inpatient admissions provided on or after October 1st in acute care hospitals will no longer be subject to the 24 days per person per fiscal year limit. Claims will be reimbursed utilizing a Diagnosis Related Groups (DRG) methodology.

(C) All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment.

(i) It is the policy and intent 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 of a Medicaid recipient. If the OHCA, or its designated agent, upon their initial review determines the admission should be denied, a notice is sent to the facility and the attending physician(s) advising them of the decision. This notice also advises that a reconsideration request may be submitted within 60 days. Additional information submitted with the reconsideration request will be reviewed by the OHCA, or its designated agent, who utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, OHCA is informed. At that point, OHCA sends a letter to the hospital and physician requesting refund of the Medicaid payment previously made on the denied admission.
(ii) If the hospital or attending physician did not request reconsideration by the OHCA, or its designated agent, the OHCA, or its designated agent, informs OHCA that there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, sends a letter to the hospital and physician requesting refund of the amount of Medicaid payment previously made on the denied admission.

(iii) If an OHCA, or its designated agent, review results in denial and the denial is upheld throughout the review process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services.

(D) If a hospital or physician believes that an acute care hospital admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient insists on treatment, the patient should be informed that he/she will be personally responsible for all charges. If a Medicaid claim is filed and paid and the service is later denied the patient is not responsible. If a Medicaid claim is not filed and paid the patient can be billed.

(E) Payment is made to a participating hospital for hospital based physician's services. The hospital must have a Hospital-Based Physician's Contract with OHCA for this method of billing.

(2) **Outpatient hospital services.**

(A) **Emergency hospital services.** Emergency department services are covered. Payment is made at a case rate which includes all non-physician services provided during the visit.

(B) **Level I - Complete Ultrasound.** Payment will be made separately from the total obstetrical care for one complete ultrasound per pregnancy when the patient has been referred to a radiologist or maternal fetal specialist trained in ultrasonography. The patient's record must be documented as to the reason the ultrasound was requested and the components of the ultrasound. The appropriate HCPC code must be used.
(C) **Level II - Targeted Ultrasound.** Payment will be made separately from the total obstetrical care for one medically necessary targeted ultrasound per pregnancy for high risk pregnancies. Documentation as to the medical justification must be made a part of the patient's record. The targeted ultrasound must be performed:

(i) with equipment capable of producing targeted quality evaluations; and

(ii) by an obstetrician certified by the American Board of Obstetrics and Gynecology as a diplomate with special qualifications in maternal fetal medicine or an active candidate for certification in maternal fetal medicine.

(iii) a complete ultrasound code is used if during the procedure it is apparent that a targeted ultrasound is not medically necessary.

(D) **Dialysis.** Payment for dialysis is made at the Medicare allowable facility rate. This rate includes all services which Medicare has established as an integral part of the dialysis procedure, such as routing medical supplies, certain laboratory procedures, oxygen, etc. Payment is made separately for injections of Epoetin Alfa (EPO or Epogen).

(E) **Technical component.** Payment is made for the technical component of outpatient radiation therapy and compensable x-ray procedures.

(F) **Laboratory.** Payment is made for medically necessary outpatient services.

(G) **Blood.** Payment is made for outpatient blood and blood fractions when these products are required for the treatment of a congenital or acquired disease of the blood.

(H) **Ambulance.**

(I) **Pharmacy.**

(J) **Home health care.** Hospital based home health providers must be Medicare certified and have a current Home Health Agency contract with the Oklahoma Health Care Authority.
(i) Payment is made for home health services provided in a patient's residence to all categorically needy individuals.

(ii) Payment is made for a maximum of 36 visits per year per eligible recipient.

(iii) Payment is made for standard medical supplies.

(iv) Payment is made on a rental or purchase basis for equipment and appliances suitable for use in the home.

(v) Non-covered items include sales tax, enteral therapy and nutritional supplies, and electro-spinal orthosis systems (ESO).

(vi) Payment may be made at a statewide procedure based rate. Payment for any combination of skilled and home health aide visits shall not exceed 36 visits per year.

(vii) Payment may be made to home health agencies for prosthetic devices.

(I) Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. A completed HCFA-484 must accompany the initial claim for oxygen. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is considered most appropriate. Refer to the Medical Suppliers Manual for further information.

(II) Payment is made for permanent indwelling catheters, drain bags, insert trays and irrigation trays. Male external catheters are also covered.

(III) Sterile tracheostomy trays are covered.

(IV) Payment is made for colostomy and urostomy bags and accessories.

(V) Payment is made for hyperalimentation, including supplements, supplies and equipment rental in behalf of persons having permanently inoperative internal body
organ dysfunction. CC-17 should be submitted to the Medical Authorization Unit. Information regarding the patient's medical condition that necessitates the hyperalimentation and the expected length of treatment, should be attached.

(VI) Payment is made for ventilator equipment and supplies when prior authorized. CC-17 should be submitted to the Medical Authorization Unit.

(VII) Medical supplies, oxygen, and equipment should be billed using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.

(K) Outpatient hospital services, not specifically addressed. Outpatient hospital services, not specifically addressed, are covered for adults only when prior authorized by the Medical Professional Services Unit of the Oklahoma Health Care Authority.

(L) Outpatient chemotherapy and radiation therapy. Payment is made for charges incurred for the administration of chemotherapy for the treatment of malignancies and opportunistic infections. Payment for radiation therapy is limited to the treatment of proven malignancies and benign conditions appropriate for stereotactic radiosurgery (e.g., gamma knife).

(M) Ambulatory surgery.

(i) Definition of Ambulatory Surgical Center. An ambulatory surgical center (ASC) is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients and which enters into an agreement with HCFA to do so. An ASC may be either independent (i.e., not part of a provider of services or any other facility) or may be operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). If an ASC is the latter type it has the option of being covered and certified under Medicare as an ASC, or of being covered as an outpatient hospital facility. In order to be covered as an ASC operated by a hospital, a facility must:
(I) elect to do so, and continue to be so covered unless HCFA determines there is good cause to do otherwise;

(II) be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital; and

(III) meet all the requirements with regard to health and safety, and agree to the assignment, coverage and reimbursement rules applied to independent ASC's.

(ii) Certification. In order to be eligible to enter into an agreement with HCFA to be covered as an ASC, a facility must be surveyed and certified as complying with the conditions for coverage for ASC's in 42 CFR 416.39-49.

(N) Outpatient surgery services. The covered facility services are defined as those services furnished by an ASC or OHF in connection with a covered surgical procedure.

(i) Services included in the facility reimbursement rate. Services included in the facility reimbursement rate are:

(I) Nursing, technical and other related services. These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the facility. In addition to the nursing staff, this category would include orderlies and others involved in patient care.

(II) Use of the patient of the facility. This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.

(III) Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment. This category includes all supplies and equipment commonly furnished by the facility in connection with surgical procedures, including any drugs and biologicals administered while the patient is in the facility. Surgical dressings, other supplies, splints, and casts include those furnished by the facility at the time of surgery. Additional supplies and materials furnished
later would generally be furnished as incident to a physician's service and not as a facility service. Supplies include those required for both the patient and facility personnel, i.e., gowns, masks, drapes, hoses, scalpels, etc., whether disposable or reusable.

(IV) Diagnostic or therapeutic items and services directly related to the surgical procedure. Payment to the facility includes items and services furnished by facility staff in connection with covered surgical procedures. These diagnostic tests include but are not limited to tests such as urinalysis, blood hemoglobin or hematocrit, CBC and fasting blood sugar, etc.

(V) Administrative, recordkeeping, and housekeeping items and services. These include the general administrative functions necessary to run the facility, such as scheduling, cleaning, utilities, rent, etc.

(VI) Blood, blood plasma, platelets, etc. Under normal circumstances, blood and blood products furnished during the course of the procedure will be included in the payment for the facility charge. In cases of patients with congenital or acquired blood disorders, additional payment can be made within the scope of the Authority's Medical Programs.

(VII) Materials for anesthesia. These include the anesthetic and any materials necessary for its administration.

(ii) Services not included in facility reimbursement rates. The following services are not included in the facility reimbursement rate:

(I) Physicians' services. This category includes most services performed in the facility which are not considered facility services. The term physicians' services includes any pre/postoperative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, or other services which the individual physician usually includes in a set "global" fee for a given surgical procedure.
(II) The sale, lease, or rental of durable medical equipment to facility patients for use in their homes. If the facility furnishes items of DME to patients it should be treated as a DME supplier and these services billed on a separate claim form. Coverage of DME is limited to the scope of the Authority's Medical Programs.

(III) Prosthetic devices. Prosthetic devices, whether implanted, inserted, or otherwise applied by covered surgical procedures are not included in the facility payment. One of the more common prosthesis is intraocular lenses (IOL's). Prosthetic devices should be billed as a separate line item using appropriate HCPCS code.

(IV) Ambulance services. If the facility furnishes ambulance services, they are covered separately as ambulance services if otherwise compensable under the Authority's Medical Programs.

(V) Leg, arm, back and neck braces. These items are not included in the facility payment. Payment is limited to the scope of the Authority's Medical Programs.

(VI) Artificial legs, arms, and eyes. This equipment is not considered part of the facility service and is not included in the facility payment rate. Payment is limited to the scope of the Authority's Medical Programs.

(VII) Services of an independent laboratory. Payment for laboratory services is limited to the scope of the Authority's Medical Programs.

(iii) Reimbursement - facility services. The facility services are reimbursed according to the group in which the surgical procedure is listed. If more than one surgical procedure is performed at the same setting, reimbursement will be made for only the major procedure. Reimbursement will be made at a state-wide payment rate based on Medicare's established groups.

(iv) Compensable procedures. The HCPCS codes identify the
compensable procedures and should be used in billing.

(O) Outpatient hospital services for persons infected with tuberculosis (TB). Outpatient hospital services are covered for persons infected with tuberculosis. Coverage includes, but may not be limited to, outpatient hospital visits, laboratory work and x-rays. Services to persons infected with TB are not limited to the scope of the Medicaid program; however, prior authorization is required for services that exceed the scope of coverage under Medicaid. Drugs prescribed for the treatment of TB not listed in OAC 317:30-3-46 require prior authorization by the University of Oklahoma College of Pharmacy using form "Petition for TB Related Therapy".

(P) Mammograms. Medicaid covers one screening mammogram and one follow-up mammogram every year for women beginning at age 30. Additional follow-up mammograms are covered when medically necessary. A prior authorization by the Medical Professional Services Division of the Oklahoma Health Care Authority is required for additional follow-up mammograms.

(Q) Treatment/Observation. Payment is made for the use of a treatment room, or for the room charge associated with outpatient observation services. Observation services must be ordered by a physician or other individual authorized by state law. Observation services are furnished by the hospital on the hospital's premises and include use of the bed and periodic monitoring by hospital staff. Payment is not made for treatment/observation on the same day as an emergency room visit. Observation services are limited to one 24 hour period per incident. Observation services are not covered in addition to an outpatient surgery.

(R) Clinic charges. Payment is made for a facility charge for services provided in non-emergency clinics operated by a hospital. This payment does not include the professional charges of the treating physician, nurse practitioner, physician assistant or charges for diagnostic testing. A facility charge is also allowed when drug and/or blood are administered outpatient.

(3) Exclusions. The following are excluded from coverage:

(A) Inpatient diagnostic studies that could be performed on
an outpatient basis.

(B) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.

(C) Reversal of sterilization procedures for the purposes of conception are not covered.

(D) Medical services considered to be experimental.

(E) Services or any expense incurred for cosmetic surgery including removal of benign skin lesions.

(F) Refractions and visual aids.

(G) Payment for the treatment of obesity.

(H) Charges incurred while patient is in a skilled nursing or swing bed.
Reimbursement will be made for inpatient hospital services rendered on or after October 1, 2005, in the following manner:

(1) Covered inpatient services provided to eligible Medicaid recipients admitted to in-state acute care and critical access hospitals will be reimbursed at a prospectively set rate which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. For each Medicaid recipient's stay, a peer group base rate is multiplied by the relative weighting factor for the DRG which applies to the hospital stay. In addition to the DRG payment, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if the DRG payment is less than $50,000 of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to 70% of the cost after the $50,000 threshold is met.

(2) The DRG payment and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) laboratory services;

(B) prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;

(C) technical component on radiology services;

(D) transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;

(E) pre-admission diagnostic testing performed within 72 hours of admission; and

(F) organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible recipients
of the Oklahoma Medicaid program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals.

(5) Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

(6) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

(7) Readmissions occurring within 15 days of prior acute care admission for a related condition will be reviewed under a retrospective utilization review policy to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the OHCA.

(8) Hospital stays less than three days in length will be reviewed under a retrospective utilization review policy for medical necessity and appropriateness of care. (Discharges involving healthy mother and healthy newborns may be excluded from this review requirement.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient stay will be denied.

(9) Organ transplants must be performed at an institution approved by the OHCA for the type of transplant provided. The transplant must be reviewed for medical appropriateness.

(10) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by Medicaid recipients and the provider will not accept the DRG payment rate. Prior authorization is required.

(11) New providers entering the Medicaid program will be
assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

(12) Payments will be made to hospitals qualifying for Disproportionate Hospital adjustments, and graduate medical education activities pursuant to the methodologies described in the Oklahoma Title XIX Inpatient Hospital Reimbursement Plan, effective date October 1, 2005, and incorporated herein by reference.
317:30-5-62. Coverage by category

(a) Adults. There is no coverage for adults.

(b) Children. Payment is made to long term care hospitals for subacute medical and rehabilitative 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.

1. Inpatient services.

(A) All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment.

(i) It is the policy and intent of the Oklahoma Health Care Authority 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 of a Medicaid recipient. If the OHCA, or its designated agent, upon their initial review determines the admission should be denied, a notice is sent to the facility and the attending physician(s) advising them of the decision. This notice also advises that a reconsideration request may be submitted within 60 days. Additional information submitted with the reconsideration request will be reviewed by the OHCA, or its designated agent, who utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, OHCA is informed. At that point, OHCA sends a letter to the hospital and physician requesting refund of the Title XIX payment previously made on the denied admission.

(ii) If the hospital or attending physician did not request reconsideration by the OHCA, or its designated agent, the OHCA, or its designated agent, informs OHCA that there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, sends a letter to the hospital and physician
requesting refund of the amount of Title XIX payment previously made on the denied admission.

(iii) If an OHCA, or its designated agent, review results in denial and the denial is upheld throughout the review process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services.

(B) If a hospital or physician believes that an long term care facility admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient insists on treatment, the patient must be informed that he/she will be personally responsible for all charges. If a Medicaid claim is filed and paid and the service is later denied the patient is not responsible. If a Medicaid claim is not filed and paid the patient can be billed.

(2) Utilization control requirements.

(A) Certification and recertification of need for inpatient care. The certification and recertification of need for inpatient care must be in writing and must be signed and dated by the physician who has knowledge of the case that continued inpatient care is required. The certification and recertification documents for all Medicaid patients must be maintained in the patient's medical records or in a central file at the facility where the patient is or was a resident.

(i) Certification. A physician must certify for each applicant or recipient that inpatient services in a long term care hospital were needed. The certification must be made at the time of admission or, if an individual applies for assistance while in a hospital, before the Medicaid agency authorizes payment.

(ii) Recertification. A physician must recertify for each applicant or recipient that inpatient services in the long term care hospital are needed. Recertification must be made at least every 60 days after certification.

(B) Individual written plan of care.

(i) Before admission to a long term care hospital, an
interdisciplinary team including the attending physician or staff physician must establish a written plan of care for each applicant or recipient. The plan of care must include:

(I) Diagnoses, symptoms, complaints, and complications indicating the need for admission,

(II) the acuity level of the individual,

(III) Objectives,

(IV) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient,

(V) Plans for continuing care, including review and modification to the plan of care, and

(VI) Plans for discharge.

(ii) The attending or staff physician and other personnel involved in the recipient's care must review each plan of care at least every 90 days.

(iii) All plans of care and plan of care reviews must be clearly identified as such in the patient's medical records. All must be signed and dated by the physician and other treatment team members in the required review interval.

(iv) The plan of care must document appropriate patient and/or family participation in the development and implementation of the treatment plan.

(C) Continued stay review. The facility must complete a continued stay review at least every 90 days.

(i) The methods and criteria for the continued stay review must be contained in the facility utilization review plan.

(ii) Documentation of the continued stay review must be clearly identified as such, signed and dated by the committee chairperson, and must clearly state the
continued stay dates and time period approved.
317:30-5-95.2. Coverage for children

The following apply to coverage for inpatient services for persons under age 21 in acute care hospitals, freestanding psychiatric hospitals and residential psychiatric treatment facilities:

(1) Pre-authorization of inpatient psychiatric services. All inpatient psychiatric services for patients under 21 years of age must be prior authorized by an agent designated by the Oklahoma Health Care Authority. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services will not be Medicaid compensable.

(A) Length of stay. The designated agent will prior authorize all services for an approved length of stay based on the medical necessity criteria described in (2)(A)-(G) of this subsection.

(B) Facility placements. Out of state placements must be approved by the agent Designated by OHCA and subsequently approved by OHCA Medicaid/Medical Services Division. Requests for admission to Residential Treatment Centers or Acute Care Units will be reviewed for consideration of level of care, availability, suitability and proximity of suitable services. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under Oklahoma Medicaid provisions as part of the per-diem rate.

(2) Inpatient services.

(A) Inpatient service limitations. Inpatient psychiatric services in all hospitals and residential psychiatric treatment facilities are limited to the approved length of stay. The Agent designated by OHCA will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria and following the current gatekeeping manual approved by the OHCA. The approved length of stay applies to both hospital and physician services.
(B) Medical necessity criteria for acute psychiatric admissions. Acute psychiatric admissions for children 13 or older must meet the terms and conditions contained in (i),(ii),(iii) and two of the (iv)(I) to (v)(III) of this subparagraph. Children 12 or younger must meet the terms or conditions contained in (i),(ii),(iii) and one of (iv)(I) to (iv)(IV), and one of (v)(I) to (v)(III) of this subparagraph.

(i) Any DSM-IV-R Axis I primary diagnosis with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-21 years of age may have an Axis II diagnosis of any personality disorder.

(ii) Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses). Adjustment or substance related disorder may be a secondary Axis I diagnosis.

(iii) It has been determined by the Gatekeeper that the current disabling symptoms could not have been managed or have not been manageable in a lesser intensive treatment program.

(iv) Within the past 48 hours the behaviors present an imminent life threatening emergency such as evidenced by:

(I) Specifically described suicide attempts, suicide intent, or serious threat by the patient.

(II) Specifically described patterns of escalating incidents of self-mutilating behaviors.

(III) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.

(IV) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.
(v) Requires secure 24-hour nursing/medical supervision as evidenced by:

(I) Stabilization of acute psychiatric symptoms.

(II) Needs extensive treatment under physician direction.

(III) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

(C) Medical necessity criteria for continued stay - acute psychiatric admission. Continued stay - acute psychiatric admissions must meet all of the conditions set forth in (i) to (iv) of this subparagraph.

(i) Any DSM-IV-R axis 1 primary diagnosis with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.

(ii) Patient continues to manifest a severity of illness that requires an acute level of care as defined in the admission criteria and which could not be provided in a less restrictive setting.

(I) Documentation of regression is measured in behavioral terms.

(II) If condition is unchanged, evidence of re-evaluation of treatment objectives and therapeutic interventions.

(iii) Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).

(iv) Documented efforts of working with child's family,
legal guardians and/or custodians and other human service agencies toward a tentative discharge date.

(D) Medical necessity criteria for admission - inpatient chemical dependency detoxification. Inpatient chemical dependency detoxification admissions must meet the terms and conditions contained in (i),(ii),(iii), and one of (iv)(I)-(iv)(IV) of this subparagraph.

(i) Any psychoactive substance dependency disorder described in DSM-IV-R with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.

(ii) Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).

(iii) It has been determined by the gatekeeper that the current disabling symptoms could not be managed or have not been manageable in a lesser intensive treatment program.

(iv) Requires secure 24-hour nursing/medical supervision as evidenced by:

(I) Need for active and aggressive pharmacological interventions.

(II) Need for stabilization of acute psychiatric symptoms.

(III) Need extensive treatment under physician direction.

(IV) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

(E) Medical necessity criteria for continued stay - inpatient chemical dependency program. No continued stay in inpatient chemical dependency program is allowed. Initial certification for admission is limited to up to five days;
exceptions may be made up to seven to eight days based on a case-by-case review.

(F) Medical necessity criteria for admission - residential treatment (psychiatric and chemical dependency). Residential Treatment Center admissions must meet the terms and conditions in (i) to (iv) and one of (v)(I)-(v)(IV), and one of (vi)(I)-(vi)(III) of this subparagraph.

(i) Any DSM-IV-R Axis 1 primary diagnosis with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.

(ii) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior, status offenses).

(iii) Patient has either received treatment in an acute care setting or it has been determined by the gatekeeper that the current disabling symptoms could not or have not been manageable in a less intensive treatment program.

(iv) Child must be medically stable.

(v) Patient demonstrates escalating pattern of self injurious or assaultive behaviors as evidenced by:

   (I) Suicidal ideation and/or threat.

   (II) History of or current self-injurious behavior.
   (III) Serious threats or evidence of physical aggression.

   (IV) Current incapacitating psychosis or depression.

(vi) Requires 24-hour observation and treatment as evidenced by:
(I) Intensive behavioral management.

(II) Intensive treatment with the family/guardian and child in a structured milieu.

(III) Intensive treatment in preparation for re-entry into community.

(G) **Medical necessity criteria for continued stay - residential treatment center.** Continued stay residential treatment center admissions must meet the terms and conditions contained in (i), (ii), (v), (vi), and either (iii) or (iv) of this subparagraph.

(i) Any DSM-IV-R Axis 1 primary diagnosis with the exception of V codes, adjustment disorders, and substance abuse related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder.

(ii) Conditions are directly attributed to a mental disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, status offenses).

(iii) Patient is making measurable progress toward the treatment objectives specified in the treatment plan.

(I) Progress is measured in behavioral terms and reflected in the patient's treatment and discharge plans.

(II) Patient has made gains toward social responsibility and independence.

(III) There is active, ongoing psychiatric treatment and documented progress toward the treatment objective and discharge.

(IV) There are documented efforts and evidence of active involvement with the family, guardian, child welfare worker, extended family, etc.

(iv) Child's condition has remained unchanged or worsened.
(I) Documentation of regression is measured in behavioral terms.

(II) If condition is unchanged, there is evidence of re-evaluation of the treatment objectives and therapeutic interventions.

(v) There is documented continuing need for 24-hour observation and treatment as evidenced by:

(I) Intensive behavioral management.

(II) Intensive treatment with the family/guardian and child in a structured milieu.

(III) Intensive treatment in preparation for re-entry into community.

(vi) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.

(3) Pre-authorization and extension procedures.

(A) Pre-admission authorization for inpatient psychiatric services must be requested from the OHCA designated agent. The OHCA or designated agent will evaluate and render a decision within 24 hours of receiving the request. A Certificate of Need will be issued by the OHCA or its designated agent, if the recipient meets medical necessity criteria.

(B) Extension requests (psychiatric) must be made through the OHCA designated agent. All requests shall be made prior to the expiration of the approved extension following the guidelines in the Gatekeeping Manual. Extension requests for the continued stay of a child who has been in an acute psychiatric program for a period of 30 days will require an evaluation by the gatekeeper and/or OHCA designated agent to determine the efficacy of treatment. Requests for the continued stay of a child who has been in an acute psychiatric program for a period of 60 days will require a review of all treatment documentation completed by the OHCA designated agent.
(C) Providers seeking prior authorization will follow OHCA's designated agent's prior authorization process guidelines for submitting behavioral health case management requests on behalf of the Medicaid recipient.

(4) **Appeal and Review Procedures.** In the event a recipient disagrees with the decision by OHCA's contractor, it receives an evidentiary hearing under OAC 317:2-1-2(a). The recipient's request for such an appeal must commence within 20 calendar days of the initial decision. Providers may access a reconsideration process by OHCA's designated agent, whose decision is final. The provider has ten business days of receipt of the decision to request the contractor to reconsider its decision. The agent will return a decision within ten working days from the time of receiving the provider's reconsideration request. The reconsideration process will end on July 1, 2006.

(5) **Quality of care requirements.**

(A) **Admission requirements.**

(i) At the time of admission to an inpatient psychiatric program, the admitting facility will provide the patient and their family or guardian with written explanation of the facility's policy regarding the following:

(I) Patient rights.

(II) Behavior Management of patients in the care of the facility.

(III) Patient Grievance procedures.

(IV) Information for contact with the Office of Client Advocacy.

(V) Seclusion and Restraint Policy.

(ii) At the time of admission to an inpatient psychiatric program, the admitting facility will provide the patient and their family or guardian with the guidelines for the conditions of family or guardian participation in the treatment of their child. The written Conditions of
Participation are provided for the facility by the Oklahoma Health Care Authority. These guidelines specify the conditions of the family or guardian's participation in "Active Treatment". The signature of the family member or guardian acknowledges their understanding of the conditions of their participation in Active Treatment while the patient remains in the care of the facility. The conditions include provisions of participation required for the continued Medicaid compensable treatment.

(B) **Individual plan of care.**

(i) "Individual plan of Care" means a written plan developed for each recipient within four days of any admission to an inpatient program which includes:

(I) the complete record of the DSM-IV five-axis diagnosis, including the corresponding symptoms, complaints, and complications indicating the need for admission,

(II) the current functional level of the individual,

(III) treatment goals and measurable time limited objectives,

(IV) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient,

(V) plans for continuing care, including review and modification to the plan of care, and

(VI) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.

(ii) The individual plan of care:

(I) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual patient and reflects the need for inpatient psychiatric care;
(II) must be developed by a team of professionals as specified in (D) of this paragraph in collaboration with the recipient, and his/her parents, legal guardians, or others in whose care he/she will be released after discharge;

(III) must establish treatment goals that are general outcome statements and reflective of informed choices of the patient served. Additionally, the treatment goal must be appropriate to the patient's age, culture, strengths, needs, abilities, preferences and limitations;

(IV) must establish measurable and time limited treatment objectives that reflect the expectations of the patient served and parent/legal guardian as well as being age, developmentally and culturally appropriate. The treatment objectives must be achievable and understandable to the patient and the parent/guardian. The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

(V) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;

(VI) must include specific discharge and after care plans that are appropriate to the patient's needs and effective on the day of discharge. At the time of discharge, after care plans will include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the recipient into their family school, and community.

(VII) must be reviewed at least every seven days by the team specified to determine that services are being appropriately provided and to recommend changes in the individual care plan as indicated by the recipient's overall adjustment, progress, symptoms, behavior, and response to treatment;

(VIII) development and review must satisfy the
utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,

(IX) and each individual plan of care review must be clearly identified as such and be signed and dated by the physician, licensed mental health professional, patient, parent/guardian, registered nurse, and other required team members. Individual plans of care and individual plan of care reviews not completed and appropriately signed will merit a penalty recoupment or will render those days non-compensable for Medicaid.

(C) **Active treatment.** Inpatient psychiatric programs must provide "Active Treatment". "Active Treatment" involves the patient and their family or guardian from the time of an admission throughout the treatment and discharge process. "Active Treatment" also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician. "Active Treatment" consists of integrated therapy components that are provided on a regular basis and will remain consistent with the patient's ongoing needs for care. The following components meet the minimum standards required for Active Treatment®, although an individual child's needs for treatment may exceed this minimum standard:

(i) Individual treatment provided by the physician. Individual treatment provided by the physician, is required three times per week for acute care and one time a week for residential care. Weekly residential treatment provided by the physician will never exceed 10 days between sessions. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.

(ii) Individual therapy. Individual therapy is defined as a method of treating existing primary mental health disorders and/or any secondary alcohol and other drug (AOD) disorders using face to face, one on one interaction between a Mental Health Professional (MHP) and a patient to promote emotional or psychological change to alleviate disorders. MHP's performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused
brief therapy or another widely accepted theoretical framework for treatment. Ongoing assessment of the patient's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal directed utilizing techniques appropriate to the individual patient's plan of care and the patient's developmental and cognitive abilities. Individual therapy must be provided two hours per week in acute care and one hour per week in residential treatment by a mental health professional as described in OAC 317:30-5-240(c). One hour of family therapy may be substituted for one hour of individual therapy at the treatment team's discretion.

(iii) Family therapy. Family therapy is defined as interaction between a MHP, patient and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding. The focus of family therapy must be directly related to the goals and objectives on the individual patient's plan of care. Family therapy must be provided one hour per week for acute care and residential treatment. One hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by a mental health professional as described in OAC 317:30-5-240(c).

(iv) Process group therapy. Process group therapy is defined as a method of treating existing primary mental health disorders and/or any secondary AOD disorders using the interaction between a mental health professional as defined in OAC 317:30-5-240(c), and two or more patients to promote positive emotional or behavioral change. The focus of the group must be directly related to goals and objectives on the individual patient's plan of care. The individual patient's behavior and the focus of the group must be included in each patient's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three hours per week in acute care and two hours per week in residential treatment
by a mental health professional as defined in OAC 317:30-5-240(c). In lieu of one hour of process group therapy, one hour of expressive group therapy may be substituted.

(v) Expressive group therapy. Expressive group therapy is defined as art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (ROPES), recreational, or occupational therapies. Through active expression, inner-strengths are discovered that can help the patient deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual patient's plan of care. Documentation must include how the patient is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant Bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy. Expressive group therapy must be provided four hours per week in acute care and three hours per week in residential treatment. In lieu of one hour of expressive group therapy, one hour of process group therapy may be substituted.

(vi) Group Rehabilitative treatment. Group rehabilitative treatment is defined as behavioral health remedial services, as specified in the individual treatment plan which are necessary for the treatment of the existing primary mental health disorders and/or any secondary AOD disorders. Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives, directly related to the individual plan of care. Group rehabilitative treatment services will be provided two hours each day for all inpatient psychiatric care. In lieu of two hours of group rehabilitative services per day, one hour of individual rehabilitative services per day may be substituted.

(vii) Individual rehabilitative treatment. Individual rehabilitative treatment is defined as a face to face service which is performed to assist patients who are
experiencing significant functional impairment due to the existing primary mental disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform activities of daily living. Services will be for the reduction of psychiatric and behavioral impairment and the restoration of functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the individualized plan of care and the patient's diagnosis. One hour of individual rehabilitative treatment service may be substituted daily for the two hour daily group rehabilitative services requirement.

(D) Credentialing requirements for treatment team members. The team developing the individual plan of care must include, at a minimum, the following:
(i) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U), and

(ii) a mental health professional licensed to practice by one of the following boards: Psychology (health service specialty only); Social Work (clinical specialty only); Licensed Professional Counselor, Licensed Behavioral Practitioner, (or) Licensed Marriage and Family Therapist or Advanced Practice Nurse (certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided), and

(iii) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

(E) Treatment team. An interdisciplinary team of a physician, mental health professionals, registered nurse, patient, parent/legal guardian, and other personnel who provide services to patients in the facility must develop the
individual plan of care, oversee all components of the active treatment and provide the services appropriate to their respective discipline. Based on education and experience, preferably including competence in child psychiatry, the teams must be capable of:

(i) Assessing the recipient's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities,

(ii) Assessing the potential resources of the recipient's family, and actively involving the family in the ongoing plan of care,

(iii) Setting treatment objectives,

(iv) Prescribing therapeutic modalities to achieve the plan objectives, and

(v) Developing appropriate discharge criteria and plans.

(F) Medical, psychiatric and social evaluations. The patient's medical record must contain complete medical, psychiatric and social evaluations.

(i) The evaluations must be completed as follows:

(I) History and physical evaluation must be completed within 60 hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N.P., or P.A.).

(II) Psychiatric evaluation must be completed within 60 hours of admission by a M.D. or D.O.

(III) Psychosocial evaluation must be completed within seven days of admission by a licensed independent practitioner (M.D., D.O., A.P.N.P., or P.A.) or a mental health professional as defined in OAC 317:30-5-240(c).

(ii) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.

(iii) Each of the evaluations must be completed when the patient changes levels of care if the existing evaluation is more than 30 days from admission. Evaluations remain
current for 12 months from the date of admission and must be updated annually.

(G) **Nursing services (inpatient psychiatric acute only).** Each facility must have a qualified Director of Psychiatric Nursing. In addition to the Director of Nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each patient. A registered nurse must document patient progress at least weekly. The progress note must contain recommendations for revisions in the treatment plan, as needed, as well as an assessment of the patient's progress as it relates to the treatment plan goals and objectives.

(H) **Seclusion and restraint incident reporting requirements.** The process by which a facility is required to inform the OHCA of a death, serious injury, or suicide attempt is as follows:

(i) The hospital administrator, executive director, or designee is required to contact the OHCA Behavioral Health Unit by phone no later than 5:00 p.m. on the business day following the incident.

(ii) Information regarding the Medicaid recipient involved, the basic facts of the incident, and follow-up to date must be reported. The agency will be asked to supply, at a minimum, follow-up information with regard to patient outcome, staff debriefing and programmatic changes implemented (if applicable).

(iii) Within three days, the OHCA Behavioral Health Unit must receive the above information in writing (example: Facility Critical Incident Report).

(iv) Patient death must be reported to the OHCA as well as to the Center for Medicare/Medicaid Regional office in Dallas, Texas.

(v) Compliance with seclusion and restraint reporting requirements will be verified during the onsite inspection of care (Section 5, Quality of Care), or using other
(I) **Other required standards.** The provider is required to maintain all programs and services according to applicable Code of Federal Regulations (CFR) requirements, JCAHO/AOA standards for Behavioral Health Care, State Department of Health Hospital Standards for Psychiatric Care, and State Department of Human Services Licensing Standards for Residential Treatment Facilities. Residential treatment facilities may substitute CARF accreditation in lieu of JCAHO or AOA accreditation.

(6) **Documentation of records.**

(A) All documentation for services provided under active treatment must be documented in an individual note and reflect the content of each session provided. Individual, Family, Process Group, Expressive Group, Individual Rehabilitative and Group Rehabilitative Services documentation must include, at a minimum, the following:

(i) date;

(ii) start and stop time for each session;

(iii) signature of the therapist and/or staff;

(iv) credentials of the therapist;

(v) specific problem(s) addressed (problems must be identified on the plan of care);

(vi) method(s) used to address problems;

(vii) progress made towards goals;

(viii) patient's response to the session or intervention; and

(ix) any new problem(s) identified during the session.

(B) Signatures of the patient, parent/ guardian, doctor, MHP, and RN are required on the Master Plan of Care and all plan of care reviews. The plan of care and plan of care review
are not valid until signed and separately dated by the patient, parent/legal guardian, doctor, RN, MHP, and all other requirements are met.

(7) **Inspection of care.**

(A) There will be an on site inspection of care of each psychiatric facility that provides care to recipients which will be performed by the OHCA or its designated agent. The Oklahoma Health Care Authority will designate the members of the Inspection of Care team. This team will consist of a Licensed Mental Health Professional, a Registered Record Administrator, and a Registered Nurse. At the team's discretion, an additional Mental Health Professional may be substituted for the Registered Record Administrator. The inspection will include observation and contact with recipients. The Inspection of Care Review will consist of recipients present or listed as facility residents at the beginning of the Inspection of Care visit as well as recipients on which claims have been filed with OHCA for acute or RTC levels of care. The review includes validation of certain factors, all of which must be met for the Medicaid Services to be compensable. Following the on-site inspection, the Inspection of Care Team will report its findings to the facility. The facility will be provided with written notification if the findings of the inspection of care have resulted in any deficiencies. Deficiencies may result in a monetary penalty, (partial per-diem) or a total (full per-diem) recoupment of the compensation received. If the review findings have resulted in a penalty status, a penalty (partial per-diem) of $50.00 per event and the days of service involved will be reported in the notification. If the review findings have resulted in full (full per-diem) recoupment status, the non-compensable days of services will be reported in the notification. In the case of non-compensable days (full per-diem) or penalties (partial per-diem) the facility will be required to refund the amount.

(B) Penalties or non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not Medicaid compensable or billable to the patient or the patient's family.
(C) If a denial decision is made, a reconsideration request may be made directly to the OHCA designated agent within 10 working days of notification of the denial. The agent will return a decision within 10 working days from the time of receiving the reconsideration request. If the denial decision is upheld, the denial can be appealed to the Oklahoma Health Care Authority within 20 working days of notification of the denial by the OHCA designated agent.
317:30-5-123. Patient certification for long term care

(a) **Medical eligibility.** Initial approval of medical eligibility for long-term care is determined by the OKDHS area nurse, or nurse designee. The certification is obtained by the facility at the time of admission.

(1) **Pre-admission screening.** Federal Regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) for individuals with mental illness and mental retardation. PASRR applies to the screening or reviewing of all individuals for mental illness or mental retardation or related conditions who apply to or reside in Title XIX certified nursing facilities regardless of the source of payment for the nursing facility services and regardless of the individual's or resident's known diagnoses. The NF must independently evaluate the Level I PASRR Screen regardless of who completes the form and determine whether or not to admit an individual to the facility. NFs which inappropriately admit a person without a PASRR Screen are subject to recoupment of funds. There are no PASRR requirements for individuals seeking residency in an intermediate care facility for the mentally retarded (ICF/MR) or in Medicare Skilled beds.

(2) **PASRR Level I screen.**

(A) Form LTC-300A, Long Term Care Pre-admission Screen, must be completed by an authorized official of OKDHS, of the nursing facility, of the hospital or a physician. An authorized official is defined as:

(i) A licensed nurse from OKDHS;

(ii) The nursing facility administrator or co-administrator;

(iii) A licensed nurse from the nursing facility, hospital, or physician's office;

(iv) A social service director from the nursing facility or hospital; or

(v) A social worker from the nursing facility, or the hospital.
(B) The authorized official as defined in (1) of this subsection must evaluate the properly completed OHCA Form LTC-300A and/or the Uniform Comprehensive Assessment Tool and/or the Minimum Data Set (MDS). Any other readily available medical and social information is also used to determine if there currently exists any indication of mental illness (MI), mental retardation (MR), or other related condition, or if such condition existed in the applicant's past history. This evaluation constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II Assessment is necessary prior to allowing the patient to be admitted.

(C) The nursing facility is responsible for determining from the evaluation whether or not the patient can be admitted to the facility. A "yes" response to any question from Form LTC-300A, Section I, will result in a consultation with the Level of Care Evaluation Unit (LOCEU) to determine if a Level II Assessment is needed. If there is any question as to whether or not there is evidence of MI, MR, or related condition, LOCEU should be contacted prior to admission.

(D) Upon receipt and review of the medical eligibility information packet, the LOCEU may, in coordination with the OKDHS area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II Assessment is not required, the process of determining medical eligibility continues. If a Level II is required, a medical decision is not made until the results of the Level II Assessment are known.

(3) Level II Assessment for PASRR.

(A) Any one of the following three circumstances will allow a patient to enter the nursing facility without being subjected to a Level II PASRR Assessment.

(i) The patient has no current indication of mental illness or mental retardation or other related condition and there is no history of such condition in the patient's past.

(ii) The patient does not have a diagnosis of mental
retardation or related condition, and a primary or secondary diagnosis of dementia including dementia of the Alzheimer's type is documented in writing by a physician.

(iii) The patient has indications of mental illness or mental retardation or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery. If an individual is admitted to an NF based on Exempted Hospital Discharge, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital Discharge is allowed if the following three conditions are met:

(I) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);

(II) The individual must require NF services for the condition for which he/she received care in the hospital; and

(III) The attending physician must certify in writing before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(B) If the patient has current indications of mental illness or mental retardation or other related condition, or if there is a history of such condition in the patient's past, the patient cannot be admitted to the nursing facility. Instead, a Level II PASRR Assessment must be performed and the results must indicate that nursing facility care is appropriate prior to allowing the patient to be admitted.

(C) The State Mental Retardation (MR) (OKDHS/Developmental Disabilities Services Division) and Mental Illness (MI) (Department of Mental Health and Substance Abuse Services) authorities have developed Advance Group Determinations by category that take into account certain diagnoses, levels of severity of illness, or need for a particular service which clearly indicate that admission to an NF is normally needed,
and that the provision of specialized services is not normally needed. These determinations are actual Level II decisions and not exemptions from the screening process. For those for whom a categorical determination is made, both the level of care determination and the specialized services determination must be addressed. All positive determinations concerning the need for specialized services must be based on a more extensive individualized evaluation.

(D) The OHCA, LOCEU, authorizes Advance Group Determinations for the MI and MR Authorities in the following categories:

(i) ** Provisional admission in cases of delirium.** Any person with mental illness, mental retardation or related condition that is not a danger to self and or others, may be admitted to a Title XIX certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

(I) A Level II evaluation is completed immediately after the delirium clears. The LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(II) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(ii) ** Provisional admission in emergency situations.** Any person with a mental illness, mental retardation or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facility for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. The LOCEU must be provided with written documentation from OKDHS Adult Protective
Services, or the NF, which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

(iii) **Respite care admission.** Any person with mental illness, mental retardation or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to 15 consecutive days per stay, not to exceed 30 days per calendar year.

(I) In rare instances, such as illness of the caregiver, an exception may be granted to allow 30 consecutive days of respite care. However, in no instance can respite care exceed 30 days per calendar year.

(II) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(4) **Resident Review.**

(A) The nursing facility's routine resident assessment will identify those individuals previously undiagnosed as MR or MI. A new condition of MR or MI must be referred to LOCEU by the NF for determination of the need for the Level II Assessment. The facility's failure to refer such individuals for a Level II Assessment will result in recoupment of funds.

(B) A Level II Resident Review must be conducted the following year for each resident of a nursing facility who was found to experience a serious mental illness on their pre-admission Level II, to determine whether, because of the resident's physical and mental condition, the resident requires the level of services provided by a nursing facility and whether the resident requires specialized services.
(C) A significant change in a resident's physical or mental condition could trigger a Level II Resident Review. If such a change should occur in a resident's condition, it is the responsibility of the nursing facility to notify the LOCEU of the need to conduct a resident review.

(5) **Results of Level II Pre-Admission Assessment and Resident Review.** Through contractual arrangements between the OHCA and the MI/MR authorities, individualized assessments are conducted and findings presented in written evaluations. The evaluations determine if nursing facility services are needed, if specialized services or lesser than specialized services are needed and what types, and if the individual meets the federal PASRR definition of mental illness or mental retardation or related conditions. Evaluations are delivered to the LOCEU to process formal, written notification to patient, guardian, NF and interested parties.

(6) **Readmissions, and interfacility transfers.** The Preadmission Screening process does not apply to readmission of an individual to an NF after transfer for a continuous hospital stay, and then back to the NF. There is no specific time limit on the length of absence from the nursing facility for the hospitalization. Inter-facility transfers are subject to Resident Reviews rather than preadmission screening. In the case of transfer of a resident from an NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent LTC-300A and any PASRR evaluations accompany the transferring resident. The receiving NF must submit an updated LTC-300A that reflects the resident's current status to LOCEU within 30 days of the transfer. Failure to do so could result in possible recoupment of funds.

(7) **PASRR appeals process.**

(A) Any individual who has been adversely affected by any PASRR determination made by the State in the context of either a preadmission screening or an annual resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county OKDHS office to discuss a hearing. Any request for a hearing must be made no later
than 20 days following the date of written notice. Appeals of these decisions are available under OAC 317:2-1-2. All individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(B) When the individual is found to experience MI, MR, or related condition through the Level II Assessment, the PASRR determination made by the MR/MI authorities cannot be countermanded by the state Title XIX agency, either in the claims process or through other utilization control/review processes, or by the state survey and certification agency. Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the MR/MI authorities.

(b) **Determination of Title XIX medical eligibility for long term care.** The determination of medical eligibility for care in a nursing facility is made by the OKDHS area nurse, or nurse designee. The procedures for determining Nursing Facility (NF) program medical eligibility are found in OAC 317:35-19. Determination of ICF/MR medical eligibility is made by LOCEU. The procedures for obtaining and submitting information required for a decision are outlined below.

(1) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ICF/MR care is based on results of a current comprehensive psychological evaluation by a licensed psychologist or state staff psychologist, documentation of MR or related condition prior to age 22, and the need for active treatment according to federal standards. Pre-approval is made by LOCEU analysts.

(2) **Medical eligibility for ICF/MR services.** Within 30 calendar days after services begin, the facility must submit the original of the Long Term Care Assessment form (LTC-300) to LOCEU. Required attachments include current (within 90 days of requested approval date) medical information signed by a physician, a current (within 12 months of requested approval date) psychological evaluation, a copy of the pertinent section of the Individual Developmental Plan or other appropriate documentation relative to discharge planning and the need for ICF/MR level of care, and a statement that the client is not an imminent threat of harm to self or others (i.e., suicidal or
homicidal). If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on MEDATS.

(3) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship to disability has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances, LOCEU will render a decision on categorical relationship using the same definition as used by SSA. A follow-up is required by the OKDHS worker with the Social Security Administration to be sure that their disability decision agrees with the decision of LOCEU.
317:30-5-124. Facility licensure

(a) **Nursing home license required.** A nursing facility must meet state nursing home licensing standards to provide, on a regular basis, health related care and services to individuals who do not require hospital care.

(1) In order for long term care facilities to receive payment from the Authority for the provision of nursing care, they must be currently licensed under provisions of Title 63 O.S., Nursing Home Care Act, 1995, Section 1-1901, et seq.

(2) The State Department of Health is responsible for the issuance, renewal, suspension and revocation of a facility's license in addition to the enforcement of the standards. The denial, suspension or revocation of a facility's license is subject to appeal to the State Department of Health. All questions regarding a facility's license should be directed to the State Department of Health.

(b) **Certification survey.** The Oklahoma State Department of Health is designated as the State Survey Agency and is responsible for determining a long term care facility's compliance with Title XIX requirements. The results of the survey are forwarded to the OHCA by the State Survey Agency.

(c) **Certification period.** The certification period of a long term care facility is determined by the State Survey Agency. In the event the facility's deficiencies are found to be of such serious nature as to jeopardize the health and safety of the patient, the State Survey Agency may terminate (de-certify) the facility's certification period and notify the Authority. Upon notification by the State Survey Agency, the Authority will notify the facility by certified letter that the Agreement is being terminated. The letter will indicate the effective date and specify the time period that payment may continue in order to allow orderly relocation of recipient/patients. The decision to terminate a facility's certification by the State Survey Agency is subject to appeal to the State Department of Health. The decision to terminate a facility's Agreement by the Authority (for a reason other than the facility decertification or suspension/revocation of the facility license) is subject to appeal to the Oklahoma Health Care Authority (see OAC 317:2-1-8 for grievance procedures and process).
(d) Certification with deficiencies.

(1) When an ICF/MR facility is certified to be in compliance with the Title XIX requirements but has deficiencies which must be corrected, an Agreement may be executed, subject to the facility's resolution of deficiencies according to the approved plan of correction. Following the visit by the State Survey Agency, one of two actions may occur:

(A) The State Survey Agency will notify the Authority that all deficiencies have been corrected or acceptable progress has been made toward correction. The Authority, by letter, will notify the facility of the action and the Agreement may run to the expiration date; or

(B) The State Survey Agency will notify the Authority that some or all of the deficiencies have not been corrected and circumstances require that the automatic cancellation date be invoked. The Authority, by certified letter, will notify the facility, owners of the facility and regulatory agencies when the automatic cancellation date is invoked.

(2) The Agreement will terminate as a result of the automatic cancellation date being invoked. In accordance with federal regulations, payment for current residents of the facility can continue for no more than thirty (30) days from the date the automatic cancellation date is invoked, to permit an orderly relocation of patients. Payment cannot be made for patients admitted after the automatic cancellation date is invoked. The decision to invoke a facility's automatic cancellation date is subject to appeal to the State Department of Health.

(e) Agreement procedures.

(1) A facility participating in the Medicaid program will be notified by letter from the Authority 60 days prior to the expiration of the existing Agreement. New Agreement forms will be sent to be completed if the facility wishes to continue participation in the Medicaid Program.

(2) Two copies of the Agreement to Provide Long Term Care Services under the Medicaid Act (Agreement) will be sent to the facility for completion. Both signed copies of the Agreement (signed with original signature only of owner, operator or
(3) When the Agreement is received, approved by the Authority, and the HCFA-1539 has been received from the State Department of Health indicating the facility's certification period, the Agreement will be completed. A copy of the executed Agreement will be returned to the facility where it must be maintained for a period of six years for inspection purposes.

(4) Intermediate care facilities for the mentally retarded wishing to participate in the ICF/MR program must be approved and certified by the State Survey Agency as being in compliance with the ICF/MR regulations (42 CFR 442 Subpart C). It is the responsibility of a facility to request the State Survey Agency perform a survey of compliance with ICF/MR regulations.

(A) When the Authority has received notification of a facility's approval as an ICF/MR and the Title XIX survey of compliance has begun, the Agreement will be sent to the facility for completion.

(B) A facility which has been certified as an ICF/MR and has an Agreement with the Authority will be paid only for recipient/patients who have been approved for ICF/MR level of care. When the facility is originally certified to provide ICF/MR services, payment for recipient/patients currently residing in the facility who are approved for a NF level of care will be made if such care is appropriate to the recipient/patient's needs.

(f) New facilities. Any new facility in Oklahoma must receive, from the State Department of Health, a Certificate of Need. When construction of a new facility is completed and licensure and certification is imminent, facilities wishing to participate in the Title XIX Medicaid Program should request, by letter, an Agreement form. When the Authority has received notification from the State Department of Health of the new facility's licensure, the Agreement will be sent to the facility for completion, if not previously sent.

(1) It is the responsibility of the new facility to request the State Survey Agency to perform a survey for Title XIX compliance.
(2) The effective date of the provider Agreement will be subsequent to completion of all requirements for participation in the Medicaid Program. In no case can payment be made for any period prior to the effective date of the facility's certification.

(g) **Change of ownership.** The acquisition of a facility operation, either whole or in part, by lease or purchase, or if a new FEIN is required, constitutes a change of ownership. When such change occurs, it is necessary that a new Agreement be completed between the new owner and the Authority in order that payment can continue for the provision of nursing care. If there is any doubt about whether a change of ownership has occurred, the facility owner should contact the State Department of Health for a final determination.

(1) **License changes due to change of ownership.** State Law prescribes specific requirements regarding the transfer of ownership of a nursing facility from one person to another. When a transfer of ownership is contemplated, the buyer/seller or lessee/lessor must notify the State Department of Health, in writing, of the forthcoming transfer at least thirty (30) days prior to the final transfer and apply for a new facility license.

(2) **Certificate of Need.** A change of ownership is subject to review by the Oklahoma State Department of Health. Any person contemplating the acquisition of a nursing facility should contact Certificate of Need Division of the State Department of Health for further information regarding Certificate of Need requirements.

(A) When a long term care facility changes ownership, federal regulations require automatic assignment of the Agreement to the new owner. An assigned Agreement is subject to all applicable statutes and regulations under which it was originally issued. This includes but is not limited to:

(i) any existing plan of correction,

(ii) any expiration date,

(iii) compliance with applicable health and safety regulations, and
(iv) compliance with any additional requirements imposed by the Medicaid agency.

(B) The new owner must obtain a Certificate of Need as well as a new facility license from the State Department of Health. Pending notification of licensure of the new owner, no changes are made to the Authority's facility records (i.e., provider number) with the exception of change in administrator or change in name, if applicable.

(C) When notification and licensure from the State Department of Health is received, procedures for transmitting forms to the facility and completing the Agreement, as described in Agreement Procedures for New Facilities, will be followed.

(D) The effective date of a facility's change of ownership is the date specified on the new license issued by the State Department of Health to the new owner or lessee.
317:30-5-131.1. Wage enhancement

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

(1) "Employee Benefits" means the benefits an employer provides to an employee which include:

(A) FICA taxes,

(B) Unemployment Compensation Tax,

(C) Worker's Compensation Insurance,

(D) Group health and dental insurance,

(E) Retirement and pensions, and

(F) Other employee benefits (any other benefit that is provided by a majority of the industry).

(2) "Enhanced" means the upward adjusted rate as required by Title 63, Section 5022 of Oklahoma Statutes.

(3) "Enhancement" means the upward adjusted rate as required by Title 63, Section 5022 of Oklahoma Statute.

(4) "Regular employee" means an employee that is paid an hourly/salaried amount for services rendered, however, the facility is not excluded from paying employee benefits.

(5) "Specified staff" means the employee positions listed in the Oklahoma Statutes under Section 5022, Title 63 that meet the requirements listed in 42 CFR Section 483.75(e)(1)-(8).

(b) Enhancement. Effective May 1, 1997, the OHCA provides a wage and salary enhancement to nursing facilities serving adults and Intermediate Care Facilities for the Mentally Retarded as required by Title 63, Section 5022 of Oklahoma Statutes. The purpose of the wage and salary enhancement is to provide an adjustment to the facility payment rate in order for facilities to reduce turnover and be able to attract and retain qualified personnel. The maximum
wage enhancement rates that may be reimbursed to the facilities per diem include:

(1) Three dollars and fifteen cents ($3.15) per patient day for NFs,

(2) Four dollars and twenty cents ($4.20) per patient day for standard private ICFs/MR, and

(3) Five dollars and fifteen cents ($5.15) per patient day for specialized private ICFs/MR.

(c) Reporting requirements. Each NF and ICF/MR is required to submit a Nursing and Intermediate Care Facilities Quarterly Wage Enhancement Report (QER) which captures and calculates specified facility expenses. The report must be completed quarterly and returned to OHCA no later than 45 days following the end of each quarter. QERs must be filed for the State Fiscal Year (SFY) which runs from July 1 to June 30. The Oklahoma Health Care Authority reserves the right to recoup all dollars that cannot be accounted for in the absence of a report. The QER is designed to capture and calculate specified facility expenses for quarterly auditing by the OHCA. The report is used to determine whether wage enhancement payments are being distributed among salaries/wages, employee benefits, or both for the employee positions listed in (1) through (8) of this subsection. Furthermore, the OHCA reserves the right to recoup all dollars not spent on salaries, wages, employee benefits, or both for the employee positions. The specified employee positions included on the QER are:

(1) Licensed Practical Nurse (LPN),

(2) Nurse Aide (NA),

(3) Certified Medication Aide (CMA),

(4) Social Service Director (SSD),

(5) Other Social Service Staff (OSSS),

(6) Activities Director (AD),

(7) Other Activities Staff (OAS), and
(8) Therapy Aide Assistant (TAA).

(d) **Timely filing and extension of time.**

(1) **Quarterly reports.** Quarterly reports are required to be filed within 45 days following the end of each quarter. This requirement is rigidly enforced unless approved extensions of time for the filing of the quarterly report is granted by OHCA. Filing extensions not to exceed 15 calendar days may be granted for extraordinary cause only. A failure to present any of the items listed in (A)-(D) of this paragraph will result in a denial of the request for an extension. The extension request will be attached to the filing of the report after the request has been granted. For an extension to be granted, the following must occur.

(A) An extension request must be received at the Oklahoma Health Care Authority on or before the 30th day after the end of the quarter.

(B) The extension must be addressed on a form supplied by the Health Care Authority.

(C) The facility must demonstrate there is an extraordinary reason for the need to have an extension. An extraordinary reason is defined in the plain meaning of the word. Therefore, it does not include reasons such as the employee who normally makes these requests was absent, someone at the facility made a mistake and forgot to send the form, the facility failed to get documents to some third party to evaluate the expenditures. An unusual and unforeseen event must be the reason for the extension request.

(D) The facility must not have any extension request granted for a period of two years prior to the current request.

(2) **Failure to file a quarterly report.** If the facility fails to file the quarterly report within the required (or extended) time, the facility is treated as out of compliance and payments made for the quarter in which no report was filed will be subject to a 100% recoupment. The overpayment is recouped in future payments to the facility immediately following the filing deadline for the reporting period. The full overpayment is
recovered within a three month period. The Oklahoma Health Care Authority reserves the right to discontinue wage enhancement payments until an acceptable QER (quarterly enhancement report) is received. In addition to the recoupment of payments, the matter of noncompliance is referred to the Legal Division of the OHCA to be considered in connection with the renewal of the facility's contract.

(3) **Ownership changes and fractional quarter report.** Where the ownership or operation of a facility changes hands during the quarter, or where a new operation is commenced, a fractional quarter report is required, covering each period of time the facility was in operation during the quarter.

(A) Fractional quarter reports are linked to the legal requirement that all facility reports be properly filed in order that the overall cost of operation of the facility may be determined.

(B) Upon notice of any change in ownership or management, the OHCA withholds payments from the facility until a fractional quarter report is received and evaluation of payment for the wage enhancement is conducted. In this case the QER is due within 15 days of the ownership or management change.

(4) **Pay periods and employee benefits reflected in the QER.** Salaries and wages are determined by accruing the payroll to reflect the number of days reported for the month. Unpaid salaries and wages are accrued through the quarter. Any salaries and wages accrued in the previous quarter and paid in the current quarter are excluded. Employee benefits are determined by accruing any benefits paid to coincide with the reporting month. Unpaid employee benefits are accrued through the quarter. Any employee benefits accrued in the previous quarter and paid in the current quarter are excluded. To be included as an allowable wage enhancement expenditure, accrued salaries, wages and benefits must be paid within forty-five (45) days from the end of the reporting quarter.

(5) **Report accuracy.** Errors and/or omissions discovered by the provider after the initial filing/approved extension are not considered grounds for re-opening/revisions of previously filed reports. Furthermore, errors and/or omission discovered by the
provider after the initial filing/approved extension can not be carried forward and claimed for future quarterly reporting periods.

(6) **False statements or misrepresentations.** Penalties for false statements or misrepresentations made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, "(a) Whoever...(2) at any time knowingly and willfully makes or cause to be made any false statement of a material fact for use in determining rights to such benefit or payment... shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with furnishing (by that person) of items or services for which payment is or may be made under this title (42 U.S.C. '1320 et. seq.), be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both."

(7) **Audits, desk and site reviews.**

(A) Upon receipt of each quarterly report a desk review is performed. During this process, the report is examined to insure it is complete. If any required information is deemed to have been omitted, the report may be returned for completion. Delays that are due to incomplete reports are counted toward the 45 day deadline outlined in (c) of this Section. At that time the mathematical accuracy of all totals and extensions is verified. Census information may be independently verified through other sources. After completion of the desk review, each report is entered into the OHCA's computerized data base. This facilitates the overall evaluation of the industry's costs.

(B) Announced and/or unannounced site reviews are conducted at a time designated by the OHCA. The purpose of site reviews is to verify the information reported on the QER(s) submitted by the facility to the OHCA. Errors and/or omissions discovered by the OHCA upon the completion of a site review is immediately reflected in future payment(s) to
the facility. The OHCA makes deficiencies known to the facility within 30 calendar days. A deficiency notice in no way prevents the OHCA from additionally finding any overpayment and adjusting future payments to reflect these findings.

(8) Appeals process.

(A) If the desk or site review indicates that a facility has been improperly paid, the OHCA will notify the facility that the OHCA will rectify the improper payment in future payments to the facility. Improper payments consist of an overpayment to a facility. The facility may appeal the determination to recoup an alleged overpayment and/or the size of the alleged overpayment, within 20 days of receipt of notice of the improper payment from the OHCA. Such appeals will be Level I proceedings heard pursuant to OAC 317:2-1-2(c)(2). The issues on appeals will be limited to whether an improper payment occurred and the size of the alleged improper payment. The methodology for determining base period computations will not be an issue considered by the administrative law judge.

(B) Certain exceptional circumstances, such as material expenses due to the use of contract employees, overtime expenses paid to direct care staff, or changes within classes of staff may have an effect on the wage enhancement payment and expense results. Facilities may demonstrate and present documentation of the affects of such circumstances before the administrative law judge.

(e) Methodology for the distribution of payments/adjustments. The OHCA initiates a two-part process for the distribution and/or recoupment of the wage enhancement.

(1) Distribution of wage enhancement revenue. All wage enhancement rates are added to the current facility per diem rate. Facilities receive the maximum wage enhancement rate applicable to each facility type.

(2) Payment/recoupment of adjustment process. Initially, all overpayments resulting from the Fourth Quarter of SFY-1997 and the First Quarter of SFY-1998 audits will be deducted from the first month's payment of the Third Quarter of SFY-1998 (January-
1998). The Fourth and First Quarter of SFY-1997 and SFY 1998 audit results will be averaged to determine the adjustment. All overpayments as a result of the Second Quarter of SFY-1998 audit will be deducted from the first month's payment of the Fourth Quarter of SFY-1998 (April-1998). Audit results will determine whether or not a facility is utilizing wage enhancement payments that are being added to the facility's per diem rate. When audit results for a given quarter after the Second Quarter of SFY-1998 (October, November, and December 1997) reflect an adjustment, recoupments will be deducted from the facility. Any adjustments calculated will not be recouped during the quarter in which the calculation is made, rather, they will be recouped during the following quarter. The recoupments, as a result of an adjustment, will not exceed the wage enhancement revenue received for the quarter in which the audit is conducted. Recoupments will be included in the facility's monthly payment and will not exceed the three month period of the quarter in which it is being recouped.

(f) Methodology for determining base year cost. The information used to calculate Base Year Cost is taken from actual SFY-1995 cost reports submitted, to the OHCA, by the NFs and ICFs/MR that will be receiving a wage enhancement. A Statewide Average Base Cost is calculated for facilities that did not submit a cost report for SFY-1995. Newly constructed facilities that submit a partial year report are assigned the lower of the Statewide Average Base Cost or actual cost. The process for calculating the Base Year Cost, the Statewide Average Base Cost, and the process for newly constructed facilities is determined as follows.

(1) Methodology used for determining base year cost. The methodology for determining the Base Year Cost is determined by the steps listed in (A) through (E) of this paragraph.

(A) Regular employee salaries are determined by adding the salaries of LPNs, NAs, CMAs, SSDs, OSSS, ADs, OAS, and TAAs.

(B) Percentage of benefits allowed are determined by dividing total facility benefits by total facility salaries and wages.

(C) Total expenditures are determined by multiplying the sum of regular employee salaries by a factor of one plus the percentage of benefits allowed in (B) of this subparagraph.
(D) Base Year PPD Costs are determined by dividing total expenditures, in (3) of this subparagraph by total facility patient days. This information is used to determine statewide average base year cost.

(E) Inflated Base Year Costs are determined by multiplying Base Year Cost, in (C) of this subparagraph by the appropriate inflation factors. Base Year Expenditures were adjusted from the midpoint of the base year to the midpoint of the rate year using the moving rate of change forecast in the Data Resources, Inc., (DRI) "HCFA Nursing Home without Capital Market Basket" Index as published for the fourth quarter of calendar year 1995. The OHCA uses this same index (DRI) for subsequent years as it becomes available and is appropriate.

(2) **Methodology used for determining Statewide Average Base Cost.** A Statewide Average Base Cost is calculated for all facilities that did not submit a cost report, to the OHCA, for SFY-1995. The steps listed in (A) through (C) of this paragraph are applied to determine the Base Cost in the absence of actual SFY-1995 cost report information.

(A) Statewide Average Base Year PPD Costs are determined by adding Base Year PPD Cost, calculated in (1)(D) of this subsection, for all facilities that submitted SFY-1995 cost reports, the sum of this calculation is then divided by the number of facilities that submitted cost reports.

(B) Inflated Base Year PPD Costs are determined by multiplying Statewide Base Year PPD Cost by the appropriate inflation factors. Statewide Base Year PPD Cost was adjusted from the midpoint of the base year to the midpoint of the rate year using the moving rate of change forecast in the Data Resources, Inc., (DRI) "HCFA Nursing Home without Capital Market Basket" Index as published for the fourth quarter of calendar year 1995. The OHCA uses this same index (DRI) for subsequent years as it becomes available and is appropriate.

(C) The facilities base cost is determined by multiplying the facilities' current quarter census by the inflated statewide average PPD costs calculated in (B) of this unit.
(g) **Methodology for determining wage enhancement revenue and expenditure results.** The methodology for determining the facilities' wage enhancement revenue and expenditures results are calculated in (1) through (3) of this paragraph.

1. **Wage enhancement revenue.** Total wage enhancement revenue received by the facility for the current quarter is calculated by multiplying the facilities total paid Medicaid days for the current quarter by the facilities wage enhancement rate. The Oklahoma Health Care Authority adjusts the computations and results when actual paid Medicaid data for the reporting quarter becomes available.

2. **Wage enhancement expenditures.** Total wage enhancement expenditures are determined in a four step process as described in (A) through (D) of this paragraph.

   (A) Total current quarter allowable expenses are calculated. Salaries and wages of specified staff are totaled and added to the applicable percent of customary employee benefits and 100% of the new employee benefits.

   (B) Base period expenditures are calculated. An occupancy adjustment factor is applied to the quarterly average base period cost to account for changes in census.

   (C) Current quarter wage enhancement expenditures are calculated by subtracting allowable base period expenditures (see (B) of this subparagraph) from total current quarter allowable expenses (see (A) of this subparagraph).

   (D) Total wage enhancement expenditures are calculated by adding current quarter wage enhancement expenditures (see (C) of this subparagraph) to prior period wage enhancement expenditures carried forward.

3. **Wage enhancement revenue and expenditure results.** Wage enhancement revenue and expenditure results are determined by comparing total wage enhancement revenue (see (1) of this paragraph) to total wage enhancement expenditures (see (2)(D) of this paragraph). Revenue exceeding expenses is subject to recoupment. Expenses exceeding revenue are carried forward to the next reporting period as a prior period wage enhancement...
expenditure carry over.
317:30-5-131.2. Quality of care fund requirements and report

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Quality of care fund assessments.

(1) The Oklahoma Health Care Authority (OHCA) was mandated by the Oklahoma Legislature to assess a monthly service fee to each Licensed Nursing Facility in the State. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.
(2) In determination of the fee for the time period beginning October 1, 2000, a survey was mailed to each licensed nursing facility requesting calendar year 1999 Total Patient Days, Gross Revenues and Contractual Allowances and Discounts. This data is used to determine the amount of fee to be assessed for the period of 10-01-00 through 06-30-01. The fee is determined by totaling the "annualized" gross revenue and dividing by the "annualized" total days of service. "Annualized" means that the surveys received that do not cover the whole year of 1999 are divided by the total number of days that are covered and multiplied by 365.

(3) The fee for subsequent State Fiscal Years is determined by using the monthly gross receipts and census reports for the six month period October 1 through March 31 of the prior fiscal year, annualizing those figures, and then determining the fee as defined above.

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

(5) The method of collection is as follows:

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

(B) Payment is due to the Oklahoma Health Care Authority by the 10th of the following month. Failure to pay the amount by the 10th or failure to have the payment mailing postmarked by the 8th will result in a debt to the State of Oklahoma and is subject to penalties of 10% of the amount and interest of 1.25% per month. The Quality of Care Fee must be submitted no later than the 10th of the month. If the 10th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m. (Central Standard Time) of the following business day.
(C) The monthly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the Authority the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

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

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

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

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

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

(A) Registered Nurse

(B) Licensed Practical Nurse

(C) Nurse Aide
(D) Certified Medication Aide

(E) Qualified Mental Retardation Professional (ICFs/MR only)

(F) Physical Therapist

(G) Occupational Therapist

(H) Respiratory Therapist

(I) Speech Therapist

(J) Therapy Aide/Assistant

(K) Social Services Director/Social Worker

(L) Other Social Services Staff

(M) Activities Director

(N) Other Activities Staff

(O) Combined Social Services/Activities

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

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

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

(d) Quality of care minimum wage for specified staff. Effective November 1, 2000, all nursing facilities and private intermediate care facilities for the mentally retarded receiving Medicaid
payments, in addition to other federal and state regulations, must pay specified staff not less than in the amount of $6.65 per hour. Employee positions included for purposes of minimum wage for specified staff are as follows:

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

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

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

(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.
(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, "Whoever...(2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefit or payment...shall (i) in the case of such statement, representation, concealment, failure, or conversion by any person in connection with furnishing (by that person) of items or services for which payment is or may be made under this title (42 U.S.C. '1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both."

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

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

(6) Facilities must submit the monthly report either through electronic mail to the Provider Compliance Audits Unit or send the monthly report in disk or paper format by certified mail and pursuant to subsection (e)(14) of this section. The submission date is determined by the date and time recorded through electronic mail or the postmark date and the date recorded on the certified mail receipt.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the Provider Compliance Audits Unit written notification with adequate, objective and substantive documentation within five business days following the submission deadline. Any documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the Oklahoma Health Care Authority.
(8) An initial administrative penalty of $150.00 is imposed upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the Authority notifying the facility in writing that the report was not complete or not timely submitted as required. The $150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For 100% private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: staffing ratios; peak in-house resident count; staff hours worked by shift; total patient days; total gross receipts; and direct-care service rates.

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

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

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

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

(14) Facilities that have been authorized by the Oklahoma State Department of Health (OSDH) to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility are required to complete the flexible staff scheduling section of Part A of the Quality of Care Report. The Owner, authorized Corporate Officer or Administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for Flexible Staff Scheduling.
317:30-5-241. Coverage for adults and children

(a) Service descriptions and conditions. Outpatient behavioral health services are covered for adults and children as set forth in this Section, unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified mental health and/or substance abuse disorder(s). All services are to be for the goal of improvement of functioning, independence, or well being of the client. The client must be able to actively participate in the treatment. Active participation means that the client must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment. The assessment must include a DSM multi axial diagnosis completed for all five axes from the most recent DSM version. All services will be subject to medical necessity criteria. For ODMHSAS Contracted and Private facilities, an agent designated by the Oklahoma Health Care Authority will apply the medical necessity criteria. For public facilities (regionally based CMHCs), the medical necessity criteria will be self-administered following the same required elements as the private and contracted (ODMHSAS) agencies under OAC 317:30-5-241(b)(4)(B)(i). Non prior authorized services will not be Medicaid compensable with the exception of Mental Health Assessment by a Non-Physician, Mental Health Service Plan Development, Crisis Intervention Services (by a MHP and Facility based), and Program of Assertive Community Treatment Services (PACT). Payment is not made for Outpatient Behavioral Health Services for children who are receiving Residential Behavioral Management Services in a Group Home or Therapeutic Foster Care with the exception of Psychotherapy services which must be authorized by the OHCA or its designated agent as medically necessary and indicated, and Crisis Intervention Services (facility based). Residents of nursing facilities are not eligible for Outpatient Behavioral Health services.

(1) Mental Health Assessment by a Non-Physician includes a history of psychiatric symptoms, concerns and problems, an evaluation of mental status, a psychosocial and medical history, a full five axes diagnosis and evaluation of current functioning, and an evaluation and assessment of alcohol and other drug use (historic and present). The service must also include an evaluation of the client's strengths and information regarding the client's treatment preferences. For adults, it may include interviews or communications with family, caretakers, or other support persons as permitted by the client.
For children under the age of 18, it must include an interview with a parent, or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an MHP.

The minimum face-to-face time spent in assessment with the client and others as identified previously in this paragraph for a low complexity Mental Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more. This service is compensable on behalf of a client who is seeking services for the first time from the contracted agency. This service is not compensable if the client has previously received or is currently receiving services from the agency, unless there has been a gap in services of more than six months and it has been more than one year since the previous assessment. This service is not allowed for AOD providers.

(2) Alcohol and Drug Assessment. Alcohol and Drug Assessment includes an assessment of past and present alcohol and other drug use. The ASI is to be completed. This service includes an evaluation of current and past functioning in all major life areas and an evaluation of potential mental illnesses that may also impact treatment. It includes a full five axes diagnosis.

The service must also include an evaluation of the client strengths and weaknesses and information regarding the client's treatment preferences. For adults, it may include interviews and/or communication with family, caretakers or other support persons as permitted by the client. For children under the age of 18, it must include an interview with a parent or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an AODTP. The minimum face to face time spent in assessment with the client (and other family or caretakers as previously described in this paragraph) for a low complexity is one and one-half hours. For a moderate complexity it is two hours or more. This service is compensable on behalf of a client who is seeking services for the first time from the contracted agency. The service is not compensable if the client has previously received or is currently receiving services from the agency, unless there has been a gap in services of more than six months and it has been more than one year since the previous assessment. This service is not allowed for Mental Health Providers.
(3) Mental Health Services Plan Development by a Non-Physician (moderate complexity). Mental Health Services Plan Development by a Non-Physician (moderate complexity) is to be performed by the practitioners and others who will comprise the treatment team. It is performed with the direct active participation of the client and a client support person or advocate if requested by the client. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. The Mental Health Services Plan is developed based on information obtained in the mental health assessment and includes the evaluation of assessment by the practitioners and the client of all pertinent information. It includes a discharge plan. It is a process whereby an individualized rehabilitation plan is developed that addresses the client's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited. For adults, it must be focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. Each type of service to be received must be delineated in the service plan and the practitioner who will be providing and responsible for each service must be identified. In addition, the anticipated frequency of each type of service must be included. This service is provided by the client treatment team. This includes all staff responsible for the treatment services delineated in the plan, the client (if over age 14), and the parent/guardian if under age 18. The service plan is not valid until it is signed and dated by the responsible MHP, the treating physician, the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met. Each signature must have the date written by the signing party on the date of signing. One unit per Medicaid recipient per provider is allowed without prior authorization. If determined by OHCA or its designated agent, one additional unit per year may be authorized.

(4) Mental Health Services Plan Development by a Non-Physician (low complexity). Mental Health Services Plan Development by a Non-Physician (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services
Plan. All elements of the plan must be reviewed with the client and treatment progress assessed. When significant progress toward recovery and the treatment goals is not occurring, the service plan must be altered in order to support and maximize progress toward recovery. When significant progress has been made, the plan must be updated to reflect the improved client's abilities and strengths and services adjusted accordingly. Mental Health Services Plan Development by a Non-Physician (low complexity) will be provided by the treatment team members. The review is not valid until signed and separately dated by the responsible MHP, the responsible physician (if client is receiving medication or otherwise under the care of the physician), the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met.

(5) Alcohol and/or Substance Abuse Services, Treatment Plan Development (moderate complexity). Alcohol and Substance Abuse Treatment Plan Development (moderate complexity) is to be performed by the AODTP practitioners and others who will comprise the treatment team. The current edition of the ASAM criteria is to be utilized and followed. The service is performed with the direct active participation of the client and a client support person or advocate if requested by the client. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. The Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the client. The service includes a discharge plan. The service is a process whereby an individualized rehabilitation plan is developed that addresses the client's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited. For adults, it must be focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. Each type of service to be received must be delineated in the service plan and the practitioner who will be providing and responsible for each service must be identified. In addition, the anticipated frequency of each type of service must be included. This
service is provided by the client treatment team. This includes all staff responsible for the treatment services delineated in the plan, the client (if over age 14), and the parent/guardian if under age 18. The service plan is not valid until it is signed and dated by the responsible AODTP, the treating physician, the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met. Each signature must have the date written by the signing party on the date of signing. One unit per Medicaid recipient per provider is allowed without prior authorization. If determined by OHCA or its designated agent, one additional unit per year may be authorized.

(6) Alcohol and/or Substance Abuse Treatment Plan Development (low complexity). Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services Plan. The ASAM criteria will be utilized in the development of the Plan. All elements of the plan must be reviewed with the client and treatment progress assessed. When significant progress toward recovery and the treatment goals is not occurring, the service plan must be altered in order to support and maximize progress toward recovery. When significant progress has been made, the plan must be updated to reflect the improved client's abilities and strengths and services adjusted accordingly. Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) will be provided by the treatment team members. The review is not valid until signed and separately dated by the responsible AODTP, the responsible physician (if client is receiving medication or otherwise under the care of the physician), the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met.

(7) Individual/Interactive Psychotherapy.

(A) Individual Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification
techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change.

(B) Interactive Psychotherapy is generally furnished to children and involves the use of physical aids and nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the client who has not yet developed or who has lost either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician. The service may be used for adults who are hearing impaired and require the use of a language interpreter due to language barriers.

(C) There are a total of six different compensable units of individual/interactive psychotherapy, three each for interactive and individual psychotherapy. They are Individual Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy in an Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes), and Interactive Psychotherapy in an office or Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes). There is a maximum of one unit of either Individual or Interactive Psychotherapy per day. With the exception of a qualified interpreter if needed, only the client and the MHP or AODTP should be present and the setting must protect and assure confidentiality. Ongoing assessment of the client's status and response to treatment as well as psychoeducational intervention are appropriate components of individual counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the client's developmental and cognitive abilities.

(D) Individual/Interactive counseling must be provided by a MHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(8) Group Psychotherapy.

(A) Group psychotherapy is a method of treating behavioral disorders using the interaction between the MHP when treating mental illness or the AODTP when treating alcohol and other drug disorders, and two or more individuals to promote
positive emotional or behavioral change. The focus of the
group must be directly related to the goals and objectives in
the individual client's current service plan. This service
does not include social or daily living skills development as
described under Individual and Group Psychosocial
Rehabilitation Services, or Alcohol and/or Substance Abuse
Services Skills Development.

(B) Group Psychotherapy must take place in a confidential
setting limited to the MHP or the AODTP conducting the
service, an assistant or co-therapist, if desired, and the
group psychotherapy participants. Group Psychotherapy is
limited to a total of eight adult individuals except when the
individuals are residents of an ICF/MR where the maximum
group size is six. For all children under the age of 18, the
total group size is limited to six. The typical length of
time for a group psychotherapy session is one hour. A
maximum of two Group Psychotherapy units per day are allowed.
Partial units are acceptable. The individual client's
behavior, the size of the group, and the focus of the group
must be included in each client's medical record. A group
may not consist solely of related individuals.

(C) Group psychotherapy will be provided by a MHP when
treatment is for a mental illness and by an AODTP when
treatment is for an alcohol or other drug disorder.

(9) Family Psychotherapy.

(A) Family Psychotherapy is a face-to-face psychotherapeutic
interaction between a MHP or an AOD and the client's family,
guardian, and/or support system. It is typically inclusive
of the identified client, but may be performed if indicated
without the client's presence. When the client is an adult,
his/her permission must be obtained. Family psychotherapy
must be provided for the direct benefit of the Medicaid
recipient to assist him/her in achieving his/her established
treatment goals and objectives and it must take place in a
confidential setting.

(B) The length of a Family Psychotherapy session is one hour.
No more than two hours of Family Psychotherapy are allowed
per day. Partial units are acceptable. Family Psychotherapy
must be provided by a MHP when treatment is for a mental
illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(10) **Psychosocial Rehabilitation Services (group).**

(A) Psychosocial Rehabilitation Services (PSR) are behavioral health remedial services which are necessary to improve the client's ability to function in the community. They are performed to improve the skills and abilities of clients to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. This service may take the form of a work units component in a General PSR program certified through the ODMHSAS. Each day of PSR must be reflected by documentation in the client records, and must include the following:

(i) date;

(ii) start and stop time(s) for each day of service;

(iii) signature of the rehabilitation clinician;

(iv) credentials of the rehabilitation clinician;

(v) specific goal(s) and/or objectives addressed (these must be identified on recovery plan);

(vi) type of skills training provided;

(vii) progress made toward goals and objectives;

(viii) client satisfaction with staff intervention; and

(ix) any new needed supports identified during service.

(B) Compensable Psychosocial Rehabilitation Services are provided to clients who have the ability to benefit from the service. The services performed must have a purpose that directly relates to the goals and objectives of the client's current service plan. A client who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.
(C) Travel time to and from PSR treatment is not compensable. Breaks, lunchtime and times when the client is unable or unwilling to participate are not compensable. The minimum staffing ratio is fourteen clients for each BHRS or MHP for adults and eight to one for children under the age of eighteen. Countable professional staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE. In order to develop and improve the client's community and interpersonal functioning and self care abilities, rehabilitation may take place in settings away from the Outpatient Behavioral Health agency site. When this occurs, the BHRS or MHP must be present and interacting, teaching, or supporting the defined learning objectives of the client for the entire claimed time. The service is a fifteen minute time frame and may be billed up to a maximum of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing transportation for recipients who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. The OHCA transportation program will arrange for transportation for those who require specialized transportation equipment. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service.

(D) A BHRS, AODTP (when treatment is for an alcohol or other drug disorder), or MHP may perform group psychosocial rehabilitation services, using a treatment curriculum approved by a MHP.

(11) Psychosocial Rehabilitation Services (individual).

(A) Psychosocial Rehabilitation (PSR) Services (individual) is performed for the same purposes and under the same description and requirements as Psychosocial Rehabilitation Services (group) [Refer to paragraph (10) of this subsection]. The service is generally performed with only the client present, but may include the client's family or support system in order to educate them about the rehabilitative activities, interventions, goals and objectives.
(B) A BHRS, AODTP (when treatment is for an alcohol or other drug disorder, or MHP must provide this service. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service. This billing unit is fifteen minutes and no more than six units per day are compensable. Children under an ODMHSAS Systems of Care program may be prior authorized additional units as part of an intensive transition period.

(12) **Psychological testing.**

(A) Psychological testing is provided by a psychologist utilizing tests selected from currently accepted psychological test batteries. Test results must be reflected in the Mental Health Services plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) Psychological testing will be provided by a psychologist, certified psychometrist, or a psychological technician of a psychologist.

(13) **Alcohol and/or Substance Abuse Services, Skills Development (group).**

(A) Alcohol and/or Substance Abuse Services, Skills Development (group) consists of the therapeutic education of clients regarding their AOD addiction or disorder. The service may also involve teaching skills to assist the individual in how to live independently in the community, improve self care and social skills and promote and support recovery. The services performed must have a purpose that directly relates to the goals and objectives of the client's current service plan. A client who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.

(B) Travel time to and from Alcohol and/or Substance Abuse Services, Skills Development is not compensable. Breaks, lunchtime and times when the client is unable or unwilling to participate are not compensable. The minimum staffing ratio is fourteen clients for each AODTP for adults and eight to one for children under the age of eighteen. This service may
be performed by an AODTP or a BHRS. In order to develop and improve the client's community and interpersonal functioning and self care abilities, services may take place in settings away from the Outpatient Behavioral Health agency site. When this occurs, the AODTP or BHRS must be present and interacting, teaching, or supporting the defined learning objectives of the client for the entire claimed time. The service is a fifteen minute time frame and may be billed up to a maximum of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing transportation for recipients who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. The OHCA transportation program will arrange for transportation for those who require specialized transportation equipment. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service.

(C) Alcohol and/or Substance Abuse Services, Skills Development are provided utilizing a treatment curriculum approved by an AODTP.

(14) Alcohol and/or Substance Abuse Services, Skills Development (individual).

(A) Alcohol and/or Substance Abuse Services, Skills Development (individual) is performed for the same purposes and under the same description and requirements as Alcohol and/or Substance Abuse Services,Skills Development (group) [Refer to paragraph (13) of this subsection]. It is generally performed with only the client present, but may include the client's family or support system in order to educate them about the rehabilitative activities, interventions, goals and objectives.

(B) An AODTP or BHRS must provide this service. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service. This billing unit is fifteen minutes and no more than six units per day are compensable.

(15) Medication Training and Support.
(A) Medication Training and Support is a documented review and educational session by a registered nurse, or physician assistant focusing on a client's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the progress notes. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the client on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization. Medication Training and Support may not be billed for Medicaid recipients who reside in ICF/MR facilities.

(B) Medication Training and Support must be provided by a licensed registered nurse, or a physician assistant as a direct service under the supervision of a physician.

(16) **Crisis Intervention Services.**

(A) Crisis Intervention Services are for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal or severe psychiatric distress. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented. Crisis Intervention Services are not compensable for Medicaid recipients who reside in ICF/MR facilities, or who receive RBMS in a group home or Therapeutic Foster home, or recipients who, while in attendance for other behavioral health services, experience acute behavioral or emotional dysfunction. The unit is a fifteen minute unit with a maximum of eight units per month and 40 units each 12 months per recipient.

(B) Crisis Intervention Services must be provided by a MHP.

(17) **Crisis Intervention Services (facility based stabilization).** Crisis Intervention Services (facility based stabilization) are emergency psychiatric and substance abuse services to resolve crisis situations. The services provided are emergency stabilization, which includes a protected
environment, chemotherapy, detoxification, individual and group treatment, and medical assessment. Crisis Intervention Services (facility based stabilization) will be under the supervision of a physician aided by a licensed nurse, and will also include MHPs for the provision of group and individual treatments. A physician must be available. This service is limited to providers who contract with or are operated by the ODMHSAS to provide this service within the overall behavioral health service delivery system. Crisis Intervention Services (facility based stabilization) are compensable for child and adult Medicaid recipients. The unit of service is per hour. Providers of this service must meet the requirements delineated in the Oklahoma Administrative Code.

(18) Program of Assertive Community Treatment (PACT) Services.

(A) Program of Assertive Community Treatment (PACT) Services are those delivered within an assertive community based approach to provide treatment, rehabilitation, and essential behavioral health supports on a continuous basis to individuals 18 years of age or older with serious mental illness with a self contained multi-disciplinary team. The team must use an integrated service approach to merge essential clinical and rehabilitative functions and staff expertise. This level of service is to be provided only for persons most clearly in need of intensive ongoing services. Services must satisfy all statutory required program elements as articulated in the Oklahoma Administrative Code 450:55. At a minimum, the services must include:

(i) Assessment and evaluation;

(ii) Treatment planning;

(iii) Crisis intervention to cover psychiatric crisis and drug and alcohol crisis intervention;

(iv) Symptom assessment, management, and individual supportive psychotherapy;

(v) Medication evaluation and management, administration, monitoring and documentation;

(vi) Rehabilitation services;
(vii) Substance abuse treatment services;
(viii) Activities of daily living training and supports;
(ix) Social, interpersonal relationship, and related skills training; and,
(x) Case management services.

(B) Providers of PACT services are specific teams within an established organization and must be operated by or contracted with and must be certified by the ODMHSAS in accordance with 43A O.S. 319 and Oklahoma Administrative Code 450:55. The unit is a per diem inclusive of all services provided by the PACT team. No more than 12 days of service per month may be claimed. Medicaid recipients who are enrolled in this service may not receive other Outpatient Behavioral Health Services except for Crisis Intervention Services (facility based stabilization).

(19) **Behavioral Health Aide.** This service is limited to children with serious emotional disturbance who are in an ODMHSAS contracted systems of care community based treatment program who need intervention and support in their living environment to achieve or maintain stable successful treatment outcomes. Behavioral Health Aides provide behavior management and redirection and behavioral and life skills remedial training. The behavioral aide also provides monitoring and observation of the child's emotional/behavioral status and responses, providing interventions, support and redirection when needed. Training is generally focused on behavioral, interpersonal, communication, self help, safety and daily living skills.

(A) Behavioral Health Aides must have completed 60 hours or equivalent of college credit to meet the requirement as a BHRS or may substitute one year of relevant employment and/or responsibility in the care of emotionally disturbed children for up to two years of college experience, and:

(i) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and
(ii) must be directly and closely supervised by a licensed
Mental Health Professional; and

(iii) function under the general direction of the established systems of care team and the current treatment plan.

(B) These services must be prior authorized by OHCA (or its designated agent).

(b) **Prior authorization and review of services requirements.**

(1) **General requirement.**

(A) All Medicaid providers who provide outpatient behavioral health services are required to have the services they provide either prior authorized or retroactively reviewed by a contractor of OHCA. Private behavioral health providers and providers identified by the ODMHSAS as contracted providers are required to have all services prior authorized with the exception of the three services listed in paragraph (2)(A) of this subsection.

(B) CMHC's, as identified by the ODMHSAS, are required to have all services retroactively reviewed by a contractor of OHCA.

(2) **Prior authorization and review of services.**

(A) All Medicaid services identified in subsection (a) of this Section must be prior authorized or reviewed as set forth in paragraph (1) of this subsection except for the following services:

(i) Mental Health Assessment by a Non-Physician [see subsection (a)(1) of this Section];

(ii) Mental Health Services Plan Development by a Non-Physician (moderate complexity) [see subsection (a)(2) of this Section]; and

(iii) Crisis Intervention Services and Adult Facility Based Crisis Intervention [see subsection (a)(17) and (18) of this Section]. Children's Facility Based Stabilization requires prior authorization.
(B) Prior authorization means the authorization of services prior to services being rendered. Should a provider perform services prior to the authorization, those services are performed at the risk of nonpayment by OHCA.

(3) Contractor for prior authorization and review of services. The contractor who performs the services identified in paragraph (1) of this subsection uses its independent medical judgment to perform both the review of services and the prior authorization of services. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.

(4) Prior authorization process.

(A) Definitions. The following definitions apply to the process of applying for an outpatient behavioral health prior authorization.

(i) "Outpatient Request for Prior Authorization" means the form used to request the OHCA contractor to approve services.

(ii) "Authorization Number" means the number that is assigned per recipient and per provider that authorizes payment after services are rendered.

(iii) "Initial Request for Treatment" means a request to authorize treatment for a recipient that has not received outpatient treatment in the last six months.

(iv) "Extension Request" means a request to authorize treatment for a recipient who has received outpatient treatment in the last six months.

(v) "Modification of Current Authorization Request" means a request to modify the current array or amount of services a recipient is receiving.

(vi) "Correction Request" means a request to change a prior authorization error made by OHCA's contractor.
(vii) "Provider change in demographic information notification" means a request to change a provider's name, address, phone, and/or fax numbers, or provider identification numbers. Change in demographics will require contractual changes with OHCA. Providers should contact OHCA's Contracts Services Division for more information.

(viii) "Status request" means a request to ask the OHCA contractor the status of a request.

(ix) "Important notice" means a notice that informs the provider that information is lacking regarding the approval of any prior authorization request.

(x) "Letter of collaboration" means an agreement between the recipient and two providers when a recipient chooses more than one provider during a course of treatment.

(B) **Process.** A provider must submit an Initial Request for Treatment, an Extension Request, a Modification of Current Authorization Request, or a Correction Request on a form provided by the OHCA contractor, prior to rendering the initial services or any additional array of services, with the exception of the three services noted in paragraph (2) of this subsection.

(i) These request forms must be fully completed including the following:

(I) pertinent demographic and identifying information;

(II) complete and current Client Assessment Record (CAR) unless another appropriate assessment tool is authorized by contractor;

(III) complete multi axial, Diagnostic and Statistical Manual (DSM) diagnosis using the most current edition;

(IV) psychiatric and treatment history;

(V) service plan with goals, objectives, treatment duration;
(VI) services requested;

(VII) signature of client on service plan; and

(VIII) appropriate provider signature on all forms.

(ii) The OHCA contractor may also require supporting
documentation for any data submitted by the provider. The
request may be denied if such information is not provided
within ten calendar days of notification of the Important
Notice.

(iii) Failure to provide a complete request form may
result in a delay in the start date of the prior
authorization.

(C) Authorization for services.

(i) Services are authorized by the contractor exercising
independent medical judgment based upon the medical data
provided by the provider. The medical data provided,
including the functional assessment (including frequency,
duration and severity of behaviors), diagnosis and other
medical history, is of paramount importance. If services
are authorized, a treatment course of one to six months
will be authorized. The authorization of services is
based upon six levels of care for children and five levels
of care for adults. The numerically based levels of care
are designed to reflect the client's acuity as each level
of care, in ascending order, provides for more services
for the recipient's care. For example, a Level I (adult)
designation provides for 1-12 RVU's while a Level II
provides for 1-20 RVU's per month. The range of RVU's
between the Level I and Level IV for both children and
adults is 1 RVU per month to 62 RVU's per month. Other
levels of care are known as Exceptional Case, 0-36 months,
ICF/MR, and RBMS.

(ii) If the provider requests services beyond the initial
prior authorization period, additional documentation is
required in the Extension Request.

(D) Appeals process. After the contractor issues a decision
regarding an Initial Prior Authorization request, an
Extension Request, a Modification Request or a Correction Request, the provider has five business days of receipt of the decision to request the contractor to reconsider its decision. The issues which a provider may ask for reconsideration are the number and type of services designated by the contractor and the length of treatment approved by the contractor. The reasoning or propriety of an Important Notice or a denial based upon insufficient data may not be reconsidered.
317:30-5-327. SoonerRide non-emergency non-ambulance transportation services for eligible medicaid recipients residing in nursing facilities

(a) Access to non-emergency non-ambulance transportation through SoonerRide.

(1) Non-emergency, non-ambulance transportation services are available through the State's SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all eligible Medicaid recipients who reside in nursing facilities.

(2) SoonerRide NET includes non-emergency, non-ambulance transportation for eligible Medicaid recipients residing in nursing facilities to and from eligible Medicaid providers of health care services. Eligible Medicaid providers are providers who have valid Oklahoma Medicaid contracts. The NET must be necessary to access medically necessary Medicaid covered services for which a recipient has available benefits. Additionally, SoonerRide NET may also be provided for eligible Medicaid recipients to providers other than Medicaid providers if the transportation is to access medically necessary services which are Medicaid coverable services.

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

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

(A) in a manner consistent with the best interest of the Medicaid recipient;

(B) similar in scope and duration state-wide, although there will be some variation based on available resources in a particular geographical area of the state;

(C) appropriate to available services; and

(D) appropriate for the limitations of the recipient.

(b) Service availability.
(1) SoonerRide NET is available for covered inpatient hospital care, outpatient hospital care, services from physicians, diagnostic devices, clinic services, eye care and dental care.

(2) SoonerRide NET is available if an eligible Medicaid recipient is being discharged from a hospital to a nursing facility. The nursing facility that the recipient is moving to will be responsible for scheduling the transportation and providing an Attendant for the recipient.

(3) In the event that an eligible Medicaid recipient is voluntarily moving from one nursing facility to another, SoonerRide will provide NET to the new facility. The nursing facility that the recipient is moving from will be responsible for scheduling the transportation and providing an Attendant for the recipient.

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

(c) **Exclusions from SoonerRide NET.** SoonerRide NET excludes:

(1) Transportation of eligible Medicaid recipients residing in nursing facilities to access emergency services.

(2) Transportation of eligible Medicaid recipients residing in nursing facilities by ambulance for any reason.

(3) Transportation of eligible Medicaid recipients residing in nursing facilities whose medical condition requires transport by stretcher.

(4) Transportation of eligible Medicaid recipients residing in nursing facilities to services that are not Medicaid covered or coverable services.

(5) Transportation of eligible Medicaid recipients residing in nursing facilities to services that are not medically necessary.

(d) **Denial of SoonerRide NET services by the SoonerRide broker.**
(1) In addition to the exclusions listed subsection (d) of this Section, the SoonerRide broker may deny NET services if:

(A) The nursing facility refuses to cooperate in determining the recipient's Medicaid eligibility.

(B) The nursing facility refuses to provide the documentation required to determine the medical necessity for NET services.

(C) The recipient or Attendant exhibits uncooperative behavior or misuses/abuses NET services.

(D) The recipient is not ready to board NET transport at the scheduled time or within 10 minutes after the scheduled pick up time.

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

(i) Urgent care.

(ii) Post-surgical and/or medical follow up care specified by a health care provider to occur in fewer than three days.

(iii) Imminent availability of an appointment with a specialist when the next available appointment would require a delay of two weeks or more.

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

(2) Pursuant to Federal law, SoonerRide will provide notification in writing to nursing facilities whose recipients have been denied services. This notification must include the specific reason for the denial and the recipient's right to appeal.

(e) SoonerRide provider network.

(1) The SoonerRide broker will maintain an adequate number of appropriate network providers to provide non-emergency, non-
ambulance transportation services for eligible Medicaid recipients residing in nursing facilities.

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

(3) SoonerRide may contract with a nursing facility or other transportation provider solely for the non-emergency, non-ambulance transportation of recipients for dialysis services.

(f) **Type of services provided and duties of the SoonerRide driver.**

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

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

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

(g) **Scheduling NET services through SoonerRide.**
(1) The nursing facility will schedule SoonerRide NET services for transportation to covered services for nursing facility eligible residents. SoonerRide NET services may be scheduled by calling the toll free SoonerRide number or by faxing a request to SoonerRide.

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

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

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

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

(6) Requests for NET Exceptional Transportation must be made through SoonerRide. Exceptional transportation service is denied as non-emergency transportation which is necessary under extraordinary medical circumstances that requires traveling out-of-state for health care treatment not normally provided through
in-state health care providers. Exceptional travel does not include direct service providers within 50 miles of the State's border counties who are utilized for routine care.

(h) Requirement for an attendant to accompany Medicaid eligible recipients who reside in nursing facilities during SoonerRide NET.

(1) When Medicaid eligible recipients residing in nursing facilities utilize SoonerRide for NET services, the nursing facility must provide an Attendant who will accompany the recipient. For purposes of SoonerRide, an Attendant is defined as an employee of a nursing facility who is provided by and trained by the nursing facility at the nursing facility's expense.

(2) An Attendant must be at least at the level of a Nurses Aide, and must have the appropriate training necessary to provide any and all assistance to the recipient, including physical assistance needed to seat the recipient in the vehicle. The Attendant must have the ability to interface with health care providers as appropriate. An attendant must be of an age of legal majority recognized under State law.

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

(4) When multiple eligible Medicaid recipients who reside in the same nursing facility are being transported to the same provider for health care services the nursing facility may provide one qualified Attendant for each three recipients unless other circumstances indicate the need for additional attendants. Such circumstances might include but are not limited to:

   (A) the physical and/or mental status of the recipient,
   (B) difficulty in getting the recipient in and out of the vehicle,
   (C) the amount of time that a recipient would have to wait unattended, etc.

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

(i) **Use of an escort to accompany Medicaid eligible recipients who reside in nursing facilities during SoonerRide NET.**

(1) In certain instances a family member or legal guardian may wish to accompany the eligible Medicaid recipient who resides in a nursing facility for health care services. In such instances, the family member or legal guardian may accompany the recipient in place of the Attendant.

(2) An Escort is defined as a family member or legal guardian whose presence is required to assist a recipient during transport and while at the place of treatment. An escort replaces the Attendant who would normally be employed by the nursing facility. An Escort voluntarily accompanies the recipient during transport and leaves the vehicle at its destination and remains with the recipient. An escort must be of an age of legal majority recognized under State law. Only one Escort may accompany a recipient. The Escort must be able to provide any services and assistance necessary to assure the safety of all passengers in the vehicle.

(3) When an Escort wishes to accompany the recipient in place of an Attendant provided by the nursing facility the Escort and the nursing facility must sign a release form stating that an Escort will be traveling with the recipient and performing the services which would normally be performed by the Attendant. This release must be faxed to the SoonerRide business office prior to the date of the transport.

(4) If an Escort is used in place of an Attendant provided by the nursing facility, that Escort cannot be counted as an Escort for any other Medicaid recipients who are traveling in the same vehicle.

(5) SoonerRide is not required to transport any additional family members other than the one family member providing Escort services. In the event that additional family members request transportation, SoonerRide may charge those family members according to SoonerRide policies which have been approved by OHCA.
(6) An Escort is not eligible for direct compensation by the SoonerRide or Medicaid program.

(j) **Transportation for dialysis Services.**

(1) For eligible Medicaid recipients residing in nursing facilities who require NET for dialysis, SoonerRide shall allow one Attendant to accompany a group of up to three dialysis patients when they are being transported for dialysis services. The Attendant will remain with the patients unless the provider of the dialysis treatment and the nursing facility sign a release form stating that the presence of the Attendant is not necessary during the dialysis treatment. This release must be faxed to the SoonerRide business office prior to the date of the dialysis service.

(2) In instances when an Attendant does not remain with the eligible Medicaid recipient during dialysis treatment, SoonerRide is not responsible for transporting the Attendant back to the nursing facility.

(3) In instances when an Attendant does not remain with the eligible Medicaid recipient during dialysis treatment, the nursing facility is responsible for providing an Attendant to accompany the recipient on the return trip from the dialysis center. The nursing facility is also responsible for transporting that Attendant to the dialysis center in order to accompany the recipient on their return trip.
317:30-5-412. Description of services

Family Support Services include the following:

(1) **Transportation services.** Transportation services are provided in accordance with OAC 317:40-5-103.

(2) **Adaptive equipment services.** Adaptive equipment (assistive technology) services are provided in accordance with OAC 317:40-5-100.

(3) **Architectural modification.** Architectural modification services are provided in accordance with OAC 317:40-5-101.

(4) **Family training.**

   (A) **Minimum qualifications.** Training providers must hold current licensure as a clinical social worker, psychologist, professional counselor, psychiatrist, registered nurse, nutritionist/dietitian, physical therapist, occupational therapist or speech therapist. Training may also be provided by other local or state agencies whose programs have been approved by the Developmental Disabilities Services Division (DDSD) Director of Training.

   (B) **Description of services.** Family Training Services include instruction in skills and knowledge pertaining to the support and assistance of persons with developmental disabilities provided to individuals and natural, adoptive or foster families of eligible individuals age six and older. Services are intended to allow families to become more proficient in meeting the needs of eligible individuals. Services are provided in any setting in which the individual/family resides and/or the provider conducts business and may be provided in either group (2-15 persons) or individual formats.

   (C) **Coverage limitations.** Payment rates and coverage limitations for family training are as follows:

      (i) Description: Individual Family Training; Limitation: $5,500 each 12 months.

      (ii) Description: Group Family Training; Limitation:
$5,500 each 12 months.

(5) **Family counseling.**

(A) **Minimum qualifications.** Counseling providers must hold current licensure as a clinical social worker, psychologist or professional counselor.

(B) **Description of services.** Family Counseling Services include counseling in emotional and social issues provided to eligible individuals age six and older and their natural, adoptive or foster families. Services are intended to maximize individual's/family's emotional/social adjustment and well-being. Services are rendered in any setting in which the individual/family resides or the provider's office and may be provided in either group (six person maximum) or individual formats.

(C) **Coverage limitations.** Payment rates and coverage limitations for family counseling are as follows:

   (i) Description: Individual Family Counseling; Unit: 15 minutes; Limitation: 400 units each 12 months.

   (ii) Description: Group Family Counseling; Unit: 30 minutes; Limitation: 225 units each 12 months.

(6) **Specialized medical supplies.**

(A) **Minimum qualifications.** Specialized medical equipment providers must meet all applicable state and local requirements for licensure and/or certification.

(B) **Description of services.** Specialized medical supplies include supplies specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living. This service also includes the purchase of ancillary supplies not available under Oklahoma’s Title XIX State Plan and excludes those items which are not of direct medical and remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. Supplies include, but are not limited to:

   (i) prescriptions in excess of Medicaid limitations;
(ii) adult briefs;

(iii) nutritional supplements;

(iv) supplies needed for tracheotomy/respirator/ventilator care; and

(v) supplies for decubitus care.

(C) **Coverage limitations.** Specialized medical services are billed using the appropriate HCPC Code. Individual limits are specified in each recipient's IHP. All services require prior authorization.
317:30-5-586.1. Prior authorization

(a) Prior authorization of services and requirements to be authorized to provide case management services is mandatory. The provider must request prior authorization from the OHCA or its designated agent. In order for the services to be prior authorized, consumer information requested must be submitted. Consumer information includes but is not limited to the following:

(1) Complete multi-axial DSM IV diagnosis with supportive documentation and mental status examination summary; and

(2) Treatment history; and

(3) Current psycho social information; and

(4) Psychiatric history; and

(5) Fully developed case management service plan, with goals, objectives, and time frames for services.

(b) Medicaid recipients will be considered for prior authorization after receipt of complete and appropriate information submitted by the provider. Based on diagnosis, functional assessment, history and other Medicaid services being received, the Medicaid recipient may be approved to receive case management services. Medicaid recipients who reside in nursing facilities, residential behavior management services, group or foster homes, or ICF/MR's may not receive Medicaid compensable case management services. A Medicaid recipient may be approved for a time frame of one to six months. The OHCA (or its designated agent) will review the request for completeness and appropriateness. The provider will be notified within 24 hours (excluding weekends and holidays) if the request is incomplete, deficient, or inappropriate, and, if so, additional information will be requested. A completed request will be reviewed and processed within 72 working hours. Requests will be reviewed by licensed master's prepared therapists (Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists) with experience in behavioral health care, Licensed Registered Nurses with experience in behavioral health care, Psychiatrists (M.D. and D.O.), or Psychologists possessing current state licensure.

(c) A prior authorization decision may be appealed by the consumer
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if filed within 20 days of receipt of the decision. Until July 1, 2006, a provider may request a reconsideration from OHCA's designated agent within five working days of receipt of the decision. The designated agent's decision regarding a reconsideration requests is final.

(d) Providers seeking prior authorization will follow OHCA's designated agent's Outpatient Behavioral Health Prior Authorization Manual guidelines for submitting requests on behalf of the Medicaid recipient.
(a) Prior authorization of behavioral health case management services is mandatory. The provider must request prior authorization from the OHCA or its designated agent.

(b) Medicaid recipients who are eligible for services will be considered for prior authorization after receipt of complete and appropriate information submitted by the provider in accordance with the guidelines for behavioral health case management services developed by OHCA or its designated agent. A Medicaid recipient may be approved for a time frame of one to six months. The OHCA (or its designated agent) will review the initial request in accordance with the guidelines for prior authorization in the Behavioral Health Case Management Manual. An initial request for case management services requires the provider to submit specific documentation to OHCA or its designated agent. A fully developed service plan is not required at the time of initial request. The provider will be given a time frame to develop the service plan while working with the child and his/her family and corresponding units of service will be approved prior to the completion of the service plan. The provider will be required to engage with the child/family within 72 hours of discharge from an inpatient psychiatric hospital and/or within 72 hours of receiving the request for services from the family or other community resource. The expectation is for the behavioral health case manager to immediately engage with the child/family to prevent hospital readmission and to refer to needed community resources. Extension requests will be reviewed by licensed master's prepared therapists (Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Licensed Behavioral Practitioners) with experience in behavioral health care, Licensed Registered Nurses with experience in behavioral health care, Psychiatrists (M.D. and D.O.), or Psychologists possessing current state licensure.

(c) In the event that a recipient disagrees with the decision by OHCA's contractor, it receives an evidentiary hearing under OAC 317:2-1-2(a). The recipient's request for such an appeal must commence within 20 calendar days of the initial decision. Providers may access a reconsideration process by OHCA's designated agent, whose decision is final. After the contractor issues a decision regarding an Initial Prior Authorization request, an
Extension Request, a Modification Request or a Correction Request, the provider has five business days of receipt of the decision to request the contractor to reconsider its decision. The issues which a provider may ask for reconsideration are the number and type of services designated by the contractor and the length of treatment approved by the contractor. The reasoning or propriety of an Important Notice or a denial based upon insufficient data may not be reconsidered. The reconsideration process will end on July 1, 2006.

(d) Providers seeking prior authorization will follow OHCA's designated agent's prior authorization process guidelines for submitting behavioral health case management requests on behalf of the Medicaid recipient.
317:30-5-746. Appeal of Prior Authorization Decision

Until July 1, 2006, if a denial decision is made, an appeal may be initiated by the resident or the residential foster care agency. The denial can be appealed to the Oklahoma Health Care Authority within 20 calendar days of the receipt of the notification of the denial by the OHCA designated agent.
317:40-7-2. Definitions

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

"Commensurate Wage" means wages paid to a worker with a disability based on the worker's productivity in proportion to the wages and productivity of workers without a disability performing essentially the same work in the same geographic area. Commensurate wages must be based on the prevailing wage paid to experienced workers without disabilities doing the same job.

"Employment Assessment" means the evaluation that identifies the unique preferences, strengths, and needs of the service recipient in relation to work. The assessment determines work skills and work behaviors, is supplemented by personal interviews and behavioral observations, and incorporates information that addresses the service recipient's desired medical, physical, psychological, social, cultural, and educational outcomes, as well as present and future employment options. The assessment, which is updated annually or more frequently as needed, includes support needs, environmental preferences, and possible accommodations.

"Enhanced Rate" means a differential rate established to provide an incentive to agencies to provide community employment services to service recipients with significant needs.

"Group Placement" means two to eight service recipients situated close together, who are provided continuous, long-term training and support in an integrated job site. Service recipients may be employed by the company or by the provider agency. The terms "work crew" and "enclave" also describe a group placement.

"Individual placement in job coaching services" means one service recipient receiving job coach services who:

(A) works in an integrated job setting;
(B) receives minimum wage or more;
(C) does not receive services from a job coach who is simultaneously responsible for continuous job coaching for a group;
(D) is employed by a community employer or the provider
agency; and

(E) has a job description that is specific to his or her work.

"Individual placement in community-based services" means the service recipient is provided supports that enable him or her to participate in approved community-based activities, as described in OAC 317:40-7-5, individually and not as part of a group placement.

"Integrated Employment Site" means an activity or job that provides regular interaction with people without disabilities, excluding service providers, to the same extent that a worker without disabilities in a comparable position interacts with others.

"Job Coach" means an individual who holds a DDSD-approved training job coach certification and provides ongoing support services to eligible persons in supported employment placements. Services directly support the service recipient's work activity including marketing and job development, job and work site assessment, training and worker assessment, job matching procedures, development of co-worker natural and paid supports, and teaching job skills.

"Job Sampling" means a paid situational assessment whereby a service recipient performs a job at a prospective employer's integrated job site, in order to determine the service recipient's interests and abilities. Situational assessments adhere to the Department of Labor (DOL) regulations regarding wages. The Team determines the appropriate type and number of situational assessments for each service recipient.

"On-Site Supports" means a situation in which the job coach is physically at the job site providing job training to a service recipient.

"Situational assessment" means a comprehensive community-based evaluation of the service recipient's functioning in relation to the supported job, including the job site, the community through which the service recipient must travel to and from the job, and the people at the job site such as the job coach, co-workers, and supervisor.

"Sub-Contract With Industry" means the provider agency enters
into a sub-contract with an industry or business to pay industry employees to provide supports to service recipients. If the industry agrees, the provider agency may contract with an employee(s) of the industry directly to provide the services. The state continues to pay the provider agency and the agency provides all pertinent information that is required for persons served by the agency. The Team determines what, if any, training is required for the employees of the industry providing services.

"Supported Employment" means competitive work in an integrated work setting with ongoing support services for service recipients for whom competitive employment has not traditionally occurred or has been interrupted or intermittent as a result of disabilities.

"Unpaid Training" means unpaid experience in integrated employment sites in accordance with DOL regulations. Service recipients do a variety of tasks, which do not equal the full job description of a regular worker.

"Volunteer Job" means an unpaid activity in which a service recipient freely participates.
317:40-7-12. Enhanced rates

An Enhanced Rate is available for both Community-Based Group Services and Group Job Coaching Services.

(1) Eligibility for an enhanced rate is determined by Team assessment as detailed in OAC 340:100-5-56, OAC 340:100-5-57, and subsection (d) of OAC 340:100-5-26 of the service recipient's needs.

(2) To be eligible for the enhanced rate, the service recipient must:

(A) have a protective intervention plan that:

(i) contains a restrictive or intrusive procedure as defined in OAC 340:100-1-2 implemented in the employment setting;

(ii) has been approved by the State Behavior Review Committee (SBRC) in accordance with OAC 340:100-3-14 or by the Developmental Disabilities Services Division (DDSD) staff in accordance with subsection (g) of OAC 340:100-5-57; and

(iii) has been reviewed by the Human Rights Committee (HRC) in accordance with OAC 340:100-3-6;

(B) have procedures included in the Individual Plan which address dangerous behavior that places the service recipient or others at risk of serious physical harm but are neither restrictive or intrusive procedures as defined in OAC 340:100-1-2. The Team submits documentation of this risk and the procedures to the positive support field specialist to assure that positive approaches are being used to manage dangerous behavior;

(C) have a visual impairment that requires assistance for mobility or safety;

(D) have two or more of the circumstances given in this subparagraph.

(i) The service recipient has medical support needs which are rated at Level 4, Level 5, or Level 6 on the Physical Status Review (PSR), explained in OAC 340:100-5-26.
(ii) The service recipient has nutritional needs supported by the PSR requiring tube feeding or other dependency for food intake which must occur in the employment setting.

(iii) The service recipient has mobility needs, supported by the PSR, such that he or she requires two or more people for lifts, transfers, and personal care. Use of a mechanical lift or other assistive technology has been evaluated for the current employment program and determined not feasible by the DDSD division director or designee; or

(E) reside in alternative group home as described in OAC 317:40-5-152.

(3) The enhanced rate can be claimed only if the person providing services fulfills all applicable training criteria specified in OAC 340:100-3-38.

(4) There are no exceptions for the enhanced rate other than as allowed in this Section.