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POLICY TRANSMITTAL NO. 06-50	DATE: NOVEMBER 2, 2006
OKLAHOMA HEALTH CARE AUTHORITY/OFFICE OF LEGISLATIVE RELATIONS & POLICY	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS & POLICY

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TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-5-41; 30-5-62; and 45-7-1.

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

SoonerCare Traditional rules are revised to remove language related to Benign Skin Lesions.

O-EPIC rules are revised to add clarification to small business requirements.

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Original signed on 11-1-06

Sharon Neuwald, Coordinator  
Office of Legislative Relations and Policy

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WF # 06-V (DT)

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## **INSTRUCTIONS FOR FILING MANUAL MATERIAL**

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

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, DHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, DHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at (405) 521-6392.

### **REMOVE**

317:30-5-41

317:30-5-62

317:45-7-1

### **INSERT**

317:30-5-41, pages 1-10, revised 7-01-06

317:30-5-62, pages 1-4, revised 7-01-06

317:45-7-1, 1 page only, revised 7-01-06

**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 1<sup>st</sup> 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 diplomat 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.

**MEDICAL PROVIDERS-FEE FOR SERVICE  
HOSPITALS SPECIFIC**

**OAC 317:30-5-41 (p4)**

(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 intra-ocular 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.

(F) Refractive and visual aids.

(G) Payment for the treatment of obesity.

(H) Charges incurred while patient is in a skilled nursing or swing bed.

**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. The reconsideration process outlined in (A) of this paragraph will end on July 1, 2006.

(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.

**317:45-7-1. Employer application and eligibility requirements for O-EPIC**

(a) In order for an employer to be eligible to participate in the O-EPIC program the employer must:

(1) have no more than a total of 25 employees on its payroll. The number of employees is determined based on the third month employee count of the most recently filed OES-3 form with the Oklahoma Employment Security Commission (OESC) and that is in compliance with all requirements of the OESC. If the employer is exempt from filing an OES-3 form, in accordance with OHCA rules, this determination is based on appropriate supporting documentation, such as the W-2 Summary Wage and Tax form as required under OAC 365:10-5-156 to verify employee count;

(2) have a business that is physically located in Oklahoma;

(3) be currently offering or intending to offer within 60 calendar days an O-EPIC Qualified Health Plan. The Qualified Health Plan coverage must begin on the first day of the month and continue through the last day of the month;

(4) offer Qualified Health Plan coverage to employees in accordance with Oklahoma Small Business Statutes, Oklahoma Department of Insurance, and all other regulatory agencies;

(5) contribute a minimum 25 percent of the eligible employee monthly health plan premium;

(b) An employer who meets all requirements listed in subsection (a) of this Section must complete and submit an employer enrollment packet to the TPA.

(c) The employer must provide its Federal Employee Identification Number (FEIN).

(d) The employer must notify the TPA, within 5 working days from occurrence, of any O-EPIC employee's termination or resignation. Additionally, the employer must notify the TPA of new hires within 30 days of eligibility for the health plan.