

---

POLICY TRANSMITTAL NO. 07-01	DATE: FEBRUARY 6, 2007
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS & POLICY

---

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:2-1-2; 2-1-5; 30-5-2; 30-5-14; 30-5-40, 30-5-40.1; 30-5-40,2;  
30-5-41; 30-5-41.1; 30-5-41.2; 30-5-42; 30-5-42.1 through 30-5-42.18;  
30-5-47; 30-5-47.1 through 30-5-47.4; 30-5-50; 30-5-56; 30-5-57;  
30-5-335; 30-5-335.1; 30-5-336; 30-5-336.1 through 30-5-336.13; 30-  
5-337; 30-5-339; 30-5-545; 30-5-566; and 30-5-567.

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

SoonerCare rules are revised to (1) provide a more timely and efficient administrative appeals process and (2) clarify and more accurately reflect utilization and costs for outpatient hospital services and freestanding ambulatory surgery centers.

Rules are revised to allow coverage for adult immunizations for vaccine preventable diseases. By maintaining recommended vaccines, SoonerCare members, their families and communities are protected from serious and often life threatening infections. Revisions provide advice and guidance on the most effective means to prevent vaccine-preventable diseases. Revision also clarify a facility's accreditation requirements to be eligible to perform organ transplants and define appropriate transplants that are reimbursable by the Agency.

Home Health Agency provider rules are revised to allow Home Health Agencies who have been deemed eligible as a Home Health Medicare provider to contract with this agency to be a SoonerCare provider.

Transportation rules are revised to establish a payment and billing method for contracted air ambulance providers that transport SoonerCare members out-of-state from the airport to the admitting hospital. Revisions also address non-emergency stretcher services and the required criteria to be eligible for stretcher services.

Original signed on 2-6-07

---

Mary Stalnaker, Director  
Family Support Services Division

---

Sharon Neuwald, Coordinator  
Office of Legislative Relations and Policy

---

WF # 07-B (NAP)

---

**INSTRUCTIONS FOR FILING MANUAL MATERIAL**

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

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

<b><u>REMOVE</u></b>	<b><u>INSERT</u></b>
317:2-1-2	317:2-1-2, pages 1-3, revised 12-1-06
317:2-1-5	317:2-1-5, pages 1-3, revised 12-1-06
317:30-5-2	317:30-5-2, pages 1-12, revised 12-1-06
317:30-5-14	317:30-5-14, pages 1-3, revised 12-1-06
317:30-5-40	317:30-5-40, 1 page only, revised 12-1-06
-----	317:30-5-40.1, 1 page only, issued 12-1-06
-----	317:30-5-40.2, 1 page only, issued 12-1-06
317:30-5-41	317:30-5-41, pages 1-2, revised 12-1-06
-----	317:30-5-41.1, 1 page only, issued 12-1-06
-----	317:30-5-41.2, 1 page only, issued 12-1-06
317:30-5-42	-----
-----	317:30-5-42.1, 1 page only, issued 12-1-06
-----	317:30-5-42.2, 1 page only, issued 12-1-06
-----	317:30-5-42.3, 1 page only, issued 12-1-06
-----	317:30-5-42.4, 1 page only, issued 12-1-06
-----	317:30-5-42.5, 1 page only, issued 12-1-06

**REMOVE**

**INSERT**

-----	317:30-5-42.6, 1 page only, issued 12-1-06
-----	317:30-5-42.7, 1 page only, issued 12-1-06
-----	317:30-5-42.8, 1 page only, issued 12-1-06
-----	317:30-5-42.9, 1 page only, issued 12-1-06
-----	317:30-5-42.10, 1 page only, issued 12-1-06
-----	317:30-5-42.11, 1 page only, issued 12-1-06
-----	317:30-5-42.12, 1 page only, issued 12-1-06
-----	317:30-5-42.13, 1 page only, issued 12-1-06
-----	317:30-5-42.14, pages 1-2, issued 12-1-06
-----	317:30-5-42.15, 1 page only, issued 12-1-06
-----	317:30-5-42.16, pages 1-3, issued 12-1-06
-----	317:30-5-42.17, 1 page only, issued 12-1-06
-----	317:30-5-42.18, 1 page only, issued 12-1-06
317:30-5-47	317:30-5-47, pages 1-2, revised 12-1-06
317:30-5-47.1	317:30-5-47.1, 1 page only, revised 12-1-06
317:30-5-47.2	317:30-5-42.2, 1 page only, revised 12-1-06
317:30-5-47.3	317:30-4-47.3, 1 page only, revised 12-1-06
317:30-5-47.4	317:30-5-47.4, 1 page only, revised 12-1-07
317:30-5-50	317:30-5-50, pages 1-2, revised 12-1-06
-----	317:30-5-56, 1 page only, issued 12-1-06
-----	317:30-5-57, pages 1-2, issued, 12-1-06
317:30-5-335	317:30-5-335, 1 page only, revised 12-21-06
-----	317:30-5-335.1, pages 1-2, issued 12-21-06
317:30-5-336	317:30-5-336, 1 page only, revised 12-21-06
-----	317:30-5-336.1, 1 page only, issued 12-21-06

**REMOVE**

**INSERT**

-----	317:30-5-336.2, 1 page only, issued 12-21-06
-----	317:30-5-336.3, 1 page only, issued 12-21-06
-----	317:30-5-336.4, 1 page only, issued 12-21-06
-----	317:30-5-336.5, 1 page only, issued 12-21-06
-----	317:30-5-336.6, 1 page only, issued 12-21-06
-----	317:30-5-336.7, 1 page only, issued 12-21-06
-----	317:30-5-336.8, pages 1-3, issued 12-21-06-
-----	317:30-5-336.9, 1 page only, issued 12-21-06
-----	317:30-5-336.10, 1 page only, issued 12-21-06
-----	317:30-5-336.11, 1 page only, issued 12-21-06
-----	317:30-5-336.12, 1 page only, issued 12-21-06
-----	317:30-5-336.13, 1 page only, issued 12-21-06
317:30-5-337	317:30-5-337, 1 page only, revised 12-21-06
317:30-5-339	317:30-5-339, 1 page only, revised 12-21-06
317:30-5-545	317:30-5-545, 1 page only, revised 12-21-06
317:30-5-566	317:30-5-566, pages 1-3, revised 12-21-06
317:30-5-567	317:30-5-567, 1 page only, revised 12-21-06



**317:2-1-2. Appeals****(a) Member Process Overview.**

(1) The appeals process allows a member to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to file an appeal, the member files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal).

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received within 30 days of written notice sent by OHCA according to Title 68 O.S. ' 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out and necessary documentation not included, then the appeal will not be heard.

(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to Section OAC 317:2-1-5. The ALJ's decision may be appealed to the CEO, which is a record review at which the parties do not appear (Section OAC 317:2-1-13).

(7) Member appeals are to be decided within 90 days from the date OHCA receives the member=s timely request for a fair hearing unless the member waives this requirement. [Title 42 U.S.C. Section 431.244(f)]

(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within 20 days of the hearing before the ALJ.

(b) **Provider Process Overview.**

(1) The proceedings as described in this Section contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(c)(2).

(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under OAC 317:2-1-2(c)(2).

(A) The Appellant (Appellant is the provider who files a grievance) files an LD form requesting a grievance hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider grievances and LD-3 forms are for nursing home wage enhancement grievances.)

(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(C) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(D) A decision will be rendered by the ALJ within 45 days of the close of all evidence in the case.

(E) The Administrative Law Judge's decision is appealable to OHCA's CEO under OAC 317:2-1-13.

(c) **ALJ jurisdiction.** The administrative law judge has jurisdiction of the following matters:

(1) Member Appeals:

(A) Discrimination complaints regarding the Medicaid program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;

(E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and

(2) Provider Appeals:

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5), (e)(8), and (e)(12);

(D) Petitions for Rulemaking;

(E) Appeals of insureds participating in O-EPIC which are authorized by OAC 317:45-9-8(a);

(F) Appeals to the decision made by the Business Contracts manager related to Purchasing as found at OAC 317:10-1-5 and other appeal rights granted by contract;

(G) Drug rebate appeals;

(H) Nursing home contracts which are terminated, denied, or non-renewed; and

(I) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions.



317:2-1-5. Hearing procedures

**Administrative Law Judge.**

(1) Hearings will be conducted in an informal manner without formal rules of evidence or procedure.

(2) No party is required to be represented by an attorney. Members may represent themselves or authorize another party to represent them. A person or entity desiring to represent a member must provide documentation of the consent of the member to be represented by that person or entity. An appeal will be rejected without documentation of representation. Individuals appearing for corporate entities will be deemed to be authorized to represent the corporation in a hearing.

(3) The docket clerk will send the Appellant and any other necessary party notice which states the hearing location, date, and time.

(4) The OHCA Administrative Law Judge or designee may:

(A) Rule on any requests for extension of time;

(B) Hold pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end in the expeditious disposition of the proceeding;

(C) Require the parties to state their positions concerning the various issues in the proceeding;

(D) Require the parties to produce for examination those relevant witnesses and documents under their control;

(E) Rule on motions and other procedural items;

(F) Regulate the course of the hearing and conduct of the participants;

(G) Establish time limits for the submission of motions or memoranda;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this Chapter which may include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;

(K) Determine the location of the hearing;

(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;

(M) Recess and reconvene the hearing;

(N) Set and/or limit the time frame of the hearing;

(O) Reconsider or rehear a matter for good cause shown; and

(P) Send a copy of the decision by the ALJ to both parties outlining their rights to appeal the decision. The decision letter need not contain findings of fact or conclusions of law.

(5) The burden of proof during the hearing will be upon the appellant and the ALJ will decide the case based upon a preponderance of evidence standard as defined by the Oklahoma Supreme Court. Parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.

(6) Parties may file preliminary motions in the case. Any such motions must be filed within 15 calendar days prior to the hearing date. Response to preliminary motions must be made within 7 calendar days of the date the motion is filed with

OHCA. Preliminary motions will be ruled upon 3 days prior to the hearing date.

(7) In any case in which a member requests a continuance, OHCA will not be prejudiced to complete the case within 90 days.



**317:30-5-2. General coverage by category**

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA's) medical programs, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all **SoonerCare** covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgicenter or a Medicare certified hospital that offers outpatient surgical services. Refer to the List of Covered Surgical Procedures.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies or opportunistic infections.

(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.

(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are

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

**OAC 317:30-5-2 (p2)**

allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare patient, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

(I) Diagnostic x-ray and laboratory services.

(J) Mammography screening and additional follow-up mammograms.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure.

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs under the jurisdiction of the Authority. A copy of the authorization, OKDHS form ABCDM-16, Authorization for Examination and Billing, must accompany the claim.

(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.

(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and, executes the federally mandated consent form (ADM-71) with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for I.U.D. insertion during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.

(P) Genetic counseling (requires special medical review prior to approval).

(Q) Weekly blood counts for members receiving the drug Clozaril.

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

**OAC 317:30-5-2 (p3)**

(R) Complete blood count (CBC) and platelet count prior to receiving chemotherapeutic agents, radiation therapy or medication such as DPA-D-Penicillamine on a regular basis for treatment other than for malignancy.

(S) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.

(T) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.

(U) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:

(i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;

(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;

(iii) Hold unrestricted license to practice medicine in Oklahoma;

(iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;

(v) Seeing members without supervision;

(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;

(vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number.

(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed

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

**OAC 317:30-5-2 (p4)**

within the context of their primary specialty and only to the extent as allowed by their accrediting body.

(V) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.

(i) Attending physician performs chart review and sign off on the billed encounter;

(ii) Attending physician present in the clinic/or hospital setting and available for consultation;

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(W) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:

(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) The contact must be documented in the medical record.

(X) Payment to a physician for supervision of CRNA services unless the CRNA bills directly.

(Y) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.

(Z) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

(i) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

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

**OAC 317:30-5-2 (p5)**

(ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(iv) Procedures considered experimental or investigational are not covered.

(AA) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB not listed in OAC 317:30-3-46 require prior authorization by the College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(EE) Smoking and Tobacco Use Cessation Counseling for treatment of individuals using tobacco.

(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:

(I) Asking the member to describe their smoking use;

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;

(IV) Assisting the member with referrals and plans to quit; and

(V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, nurse practitioners, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff. It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP capitation payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note and signature along with the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(FF) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(2) General coverage exclusions include the following:

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

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of

care in response to changes in the member=s status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member=s care, the procedure codes for subsequent hospital care must be used.

(D) Refractions and visual aids.

(E) A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care.

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomy.

(I) Medical services considered to be experimental or investigational.

(J) Payment for more than four outpatient visits per month (home or office) per member except those visits in connection with family planning, or related to emergency medical conditions.

(K) Payment for more than two nursing facility visits per month.

(L) More than one inpatient visit per day per physician.

(M) Physician supervision of hemodialysis or peritoneal dialysis.

(N) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.

(O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

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

**OAC 317:30-5-2 (p8)**

(P) Payment for the services of physicians' assistants, social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(Q) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury, or illness related to a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest.  
(Refer to OAC 317:30-5-6 or 317:30-5-50.)

(R) Night calls or unusual hours.

(S) Speech and Hearing services.

(T) Mileage.

(U) A routine hospital visit on the date of discharge unless the member expired.

(V) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(W) Inpatient chemical dependency treatment.

(X) Fertility treatment.

(Y) Payment for removal of benign skin lesions unless medically necessary.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's medical programs, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under 21 years of age must be prior authorized by an agency designated by the

Oklahoma Health Care Authority. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not be SoonerCare compensable.

(A) Effective October 1, 1993, all residential and acute psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25, 317:30-5-95.27 and 317:30-5-95.29.

(B) Out of state placements will not be authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all

hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment program.** Payment is made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

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

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

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

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same member at the same time, except when

warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the codes for subsequent hospital care must be used.

(D) A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care.

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of persons who are under 21 years of age.

(G) Non-therapeutic hysterectomy.

(H) Medical Services considered to be experimental or investigational.

(I) More than one inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest.  
(Refer to OAC 317:30-5-6 or 317:30-5-50.)

(K) Physician supervision of hemodialysis or peritoneal dialysis.

(L) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.

(M) Payment for the services of physicians' assistants except as specifically set out in OHCA rules.

(N) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(P) Night calls or unusual hours.

(Q) Mileage.

(R) A routine hospital visit on date of discharge unless the member expired.

(S) Tympanometry.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. For in-State physicians, claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment in order to be considered timely filed. The Medicare EOMB must be attached to the claim. If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare".

(1) Out of state claims will not "cross over". Providers must file a claim for coinsurance and/or deductible within 90 days of the Medicare payment. The Medicare EOMB must be attached to the claim.

(2) Claims filed under SoonerCare must be filed within one year from the date of service. For dually eligible members, to be eligible for payment of coinsurance and/or deductible under SoonerCare, a claim must be filed with Medicare within one year from the date of service.

**317:30-5-14. Injections**

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

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

(2) **Immunizations for adults.** Coverage for adults is provided as per the Advisory Committee on Immunization Practices (ACIP) guidelines.

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

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

(2) Agents used to promote fertility;

(3) Agents used to promote hair growth;

(4) Agents used for cosmetic purposes;

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

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

(7) Vitamins and Minerals with the following exception:

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

(B) Vitamin K injections are compensable; and

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

**OAC 317:30-5-14 (p2)**

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

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

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

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

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

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

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

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

**OAC 317:30-5-14 (p3)**

---

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



**317:30-5-40. Eligible providers**

(a) All general medical/surgical hospitals and critical access hospitals eligible for reimbursement under this Part must be licensed by the appropriate state survey agency, meet Medicare conditions of participation, and have a current contract on file with the Oklahoma Health Care Authority (OHCA).

(b) Children specialty hospitals must be appropriately licensed and certified and have a current contract with the OHCA.

(c) Eligibility requirements for specialized rehabilitation hospitals are covered in OAC 317:30-5-110; inpatient psychiatric hospitals are covered in OAC 317:30-5-95. Requirements for long term care hospitals are found in OAC 317:30-5-60.

(d) Certain providers who provide professional and other services within an inpatient or outpatient hospital require separate contracts with the OHCA.

(e) Reimbursement for laboratory services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from the Center for Medicare and Medicaid Services (CMS) and have a current contract on file with this Authority.



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

**OAC 317:30-5-40.1**

**317:30-5-40.1. General information**

(a) This Chapter applies to coverage in an inpatient and/or outpatient setting. Coverage is the same for adults and children unless otherwise indicated.

(b) **Professional Services.** Payment is made to a participating hospital group or corporation for hospital based physician's services. The hospital must have a Hospital Group Physician's Contract with OHCA for this method of billing.

(c) **Prior Authorization.** OHCA requires prior authorization for certain procedures to validate the medical need for the service.

(d) **Medical necessity.** Medical necessity requirements are listed at OAC 317:30-3-1(f).



**317:30-5-40.2 Definitions**

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

"CMS" means the Center for Medicare and Medicaid Services

"Diagnosis Related Group" means a patient classification system that relates types of patients treated to the resources they consume.



**317:30-5-41. Inpatient hospital coverage/limitations**

(a) Covered hospital inpatient services are those medically necessary services which require an inpatient stay ordinarily furnished by a hospital for the care and treatment of inpatients and which are provided under the direction of a physician or dentist in an institution approved under OAC:317:30:5-40.1(a) or (b). Effective October 1, 2005, claims for inpatient admissions provided on or after October 1<sup>st</sup> in acute care or critical access hospitals are reimbursed utilizing a Diagnosis Related Groups (DRG) methodology.

(b) **Inpatient status.** OHCA considers a member an inpatient when the member is admitted to the hospital and is counted in the midnight census. In situations when a member inpatient admission occurs and the member dies, is discharged following an obstetrical stay, or is transferred to another facility on the day of admission, the member is also considered an inpatient of the hospital.

(1) **Same day admission.** If a member is admitted and dies before the midnight census on the same day of admission, the member is considered an inpatient.

(2) **Same day admission/discharge C obstetrical and newborn stays.** A hospital stay is considered inpatient stay when a member is admitted and delivers a baby, even when the mother and baby are discharged on the date of admission (i.e., they are not included in the midnight census). This rule applies when the mother and/or newborn are transferred to another hospital.

(3) **Discharges and Transfers.**

(A) **Discharges.** A hospital inpatient is considered discharged from a hospital paid under the DRG-based payment system when:

(i) The patient is formally released from the hospital; or

(ii) The patient dies in the hospital; or

(iii) The patient is transferred to a hospital that is excluded from the DRG-based payment system, or transferred to a distinct part psychiatric or rehabilitation unit of

the same hospital. Such instances will result in two or more claims. Effective January 1, 2007, distinct part psychiatric and rehabilitation units excluded from the Medicare Prospective Payment System (PPS) of general medical surgical hospitals will require a separate provider identification number.

**(B) Transfers.**

(i) A discharge of a hospital inpatient is considered to be a transfer for purposes of payment if the discharge is made from a hospital included under the DRGBbased payment system to the care of another hospital that is:

(I) paid under the DRG-based payment system and in such instances the result will be that two (or more) claims will be generated; or

(II) to a hospital excluded from the DRG-based payment system. Such instances will result in two or more claims.

(ii) Transfers from one inpatient area or unit of a DRG-based hospital to another inpatient area or unit of the same hospital will result in a single claim unless it is a distinct part unit as defined in (A)(iii).

**(C) Leaves of Absence.** OHCA considers a discharge as occurring when the member leaves the hospital for any reason other than a "leave of absence." Normally a patient will leave a hospital only as a result of a discharge or transfer. However, there are some circumstances where a patient is admitted for care, and for some reason is sent home temporarily before that care is completed. Hospitals may place patients on leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples of such situations include, but are not limited to, situations where surgery could not be scheduled immediately, additional testing which is not available at that particular time, or a change in the patient=s condition.

317:30-5-41.1. Acute inpatient psychiatric services

(a) Inpatient stays in a psychiatric unit of a general medical/surgical hospital are covered for members of any age. See OAC 317:30-5-95 for coverage in a freestanding psychiatric hospital or psychiatric residential treatment facility.

(b) **Utilization Control.** All psychiatric admissions must be prior authorized. SoonerCare utilization control requirements applicable to inpatient psychiatric services in freestanding psychiatric hospitals apply to acute care hospitals. Acute care hospitals are required to maintain the same level of documentation on individuals receiving psychiatric services as the freestanding psychiatric facilities (refer to OAC 317:30-5-95.12).



**317:30-5-41.2. Organ transplants**

Solid organ and bone marrow/stem cell transplants are covered when appropriate and medically necessary.

(1) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(2) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(3) To be compensable under the SoonerCare program all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(4) Procedures considered experimental or investigational are not covered.

(5) Donor expenses are not covered.



**317:30-5-42.1. Outpatient hospital services**

(a) Hospitals providing outpatient hospital services are required to meet the same requirements that apply to OHCA contracted, non-hospital providers performing the same services. Outpatient services performed outside the hospital facility are not reimbursed as hospital outpatient services.

(b) Covered outpatient hospital services must meet all of the criteria listed in (1) through (4) of this subsection.

(1) The care is directed by a physician or dentist.

(2) The care is medically necessary.

(3) The member is not an inpatient.

(4)The service is provided in an approved hospital facility.

(c) Covered outpatient hospital services are those services provided for a member who is not a hospital inpatient. A member in a hospital may be either an inpatient or an outpatient, but not both (see OAC 317:30-5-41).



317:30-5-42.2. Blood and blood fractions

Payment is made for blood and blood fractions and the administration of blood and blood fractions when these products are required for the treatment of a congenital or acquired disease of the blood and not available from another source.



317:30-5-42.3. Chemotherapy and radiation therapy

Payment is made for charges incurred for the administration of chemotherapy for the treatment of medically necessary and medically approved procedures. Payment for radiation therapy is limited to the treatment of proven malignancies and benign conditions appropriate for stereotactic radiosurgery (e.g., gamma knife).



**317:30-5-42.4. Clinic/treatment room services; urgent care**

(a) An outpatient hospital clinic is a non-emergency service providing diagnostic, preventive, curative and rehabilitative services on a scheduled basis.

(b) Urgent care payment is made 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.

(c) Urgent Care services will not require a referral for SoonerCare Choice members however other claims will deny without a referral.

(d) Adults are limited to four clinic visits per month.



**317:30-5-42.5. Diagnostic testing therapeutic services**

(a) Reimbursement is made for diagnostic testing to diagnose a disease or medical condition.

(b) Separate payment may be made for ancillary services that are not covered as an integral part of a facility fee.



**317:30-5-42.6. Dialysis**

Payment for dialysis is made at the all-inclusive Medicare allowable composite rate. This rate includes all services which Medicare has established as an integral part of the dialysis procedure, such as routine medical supplies, certain laboratory procedures, oxygen, etc. Payment is made separately for injections of Epoetin Alfa (EPO or Epogen). The physician is reimbursed separately.



**317:30-5-42.7. Emergency department (ED) care/services**

Emergency department care must:

(1) Be provided in a hospital with a designated emergency department; and

(2) Provide direct patient care, including patient assessment, monitoring, and treatment by hospital medical personnel such as physicians, nurses, or lab and x-ray technicians.

(A) Medical records must document the emergency diagnosis and the extent of direct patient care.

(B) Emergency department care does not include unattended waiting time.

(C) Emergency services are covered for a medical emergency. This means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(i) Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or continuation of severe pain;

(ii) serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or death.

(D) Labor and delivery is a medical emergency, if it meets this definition.

(3) Prescheduled services are not considered an emergency.

(4) Services provided as follow-up to initial emergency care are not considered emergency services.



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

**OAC 317:30-5-42.8**

---

**317:30-5-42.8. Hearing and speech therapy**

Payment is covered for hearing and speech services, including evaluations, for children when prior authorized.



317:30-5-42.9. Infusions/injections

Intramuscular, subcutaneous or intravenous injections and intravenous (IV) infusions are covered when medically necessary and not considered a compensable part of the procedure.



**317:30-5-42.10. Laboratory**

Payment is made for all laboratory tests listed in the Clinical Diagnostic Laboratory fee schedule from CMS. To be eligible for payment as a laboratory/pathology service, the service must be:

- (1) Ordered and provided by or under the direction of a physician or other licensed practitioner within the scope of practice as defined by state law;
- (2) Provided in a hospital or independent laboratory;
- (3) Directly related to the diagnosis and treatment of a medical condition; and
- (4) Authorized under the laboratory's CLIA certification.



**317:30-5-42.11. Observation/treatment**

(a) Payment is made for the use of a treatment room 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. Observation services must include a minimum of 8 hours of continuous care. Outpatient observation services are not covered when they are provided:

(1) On the same day as an emergency department visit.

(2) Prior to an inpatient admission, as those observation services are considered part of the inpatient DRG.

(3) For the convenience of the member, member=s family or provider.

(4) When specific diagnoses are not present on the claim.

(b) Payment is made for observation services in a labor or delivery room. Specific pregnancy-related diagnoses are required. During active labor, a fetal non-stress test is covered in addition to the labor and delivery room charge.



MEDICAL PROVIDERS-FEE FOR SERVICE  
HOSPITALS SPECIFIC

OAC 317:30-5-42.12

---

317:30-5-42.12. Physical therapy

Payment is made for preauthorized outpatient physical therapy, including evaluations, for children.



317:30-5-42.13. Radiology

Payment is made for the technical component of outpatient radiation therapy and compensable x-ray procedures.

(1) **Mammograms.** Medically necessary screening mammography is a covered benefit. Additional follow-up mammograms are covered when medically necessary.

(2) **Ultrasounds.** Ultrasounds for obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b)(2)(A)-(C).



**317:30-5-42.14. Surgery**

**(a) Reimbursement.** Reimbursement is made for selected surgeries performed in an outpatient hospital. When an ambulatory surgery is performed in the inpatient hospital setting, the physician must provide exception rationale justifying the need for an inpatient setting to OHCA medical staff for review.

**(b) Ambulatory Surgery Center Groups.** The Medicare definition of covered Ambulatory Surgery Center (ASC) facility services includes services furnished on a outpatient basis in connection with a covered surgical procedure. This is a bundled payment that includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use to patients scheduled for surgical procedures. It includes all services and procedures in connection with covered procedures provided by facility personnel and others involved in patient care. These services do not include physician services, or other health services for which payment can be made under other OHCA medical program provisions (e.g., services of an independent laboratory located on the same site as the ASC, prosthetic devices other than intra ocular lenses (IOLs), anesthetist services, DME).(See OAC 317:30-5-565 for items separately billable.)

**(c) Ambulatory Patient Classification (APC) Groups.** Certain surgical services filed with revenue code series 36X and 49X and that do not fall within an Ambulatory Patient Classification (ASC) group will pay a SoonerCare rate based on Medicare's APC groups. This is not a bundled rate. Other lines on the claim may pay.

**(d) Multiple Surgeries.** Multiple surgeries refers to more than one surgical procedure done on the same person on the same day. The multiple surgery rule provides that under certain circumstances the second and subsequent surgeries are paid at a lesser amount. When multiple ASCs or APCs are performed in the same operative session, payment will be the rate of the procedure in the highest payment group.

**(e) Minor procedures.** Minor procedures that are normally performed in a physician's office are not covered in the outpatient hospital unless medically necessary.

**(f) Dental Procedures.** Dental services are routinely rendered in the dental office, unless the situation requires that the dental

service be performed in the outpatient hospital setting. However, services are not covered in the outpatient hospital setting for the convenience of the dentist or member. Dental procedures are not covered as Medicare ASC procedures. For OHCA payment purposes, the ASC list has been expanded to cover these services for children. Non-emergency routine dental that is provided in an outpatient hospital setting is covered only under the following circumstances for children or adults who are residents in ICFs/MR:

- (1) A concurrent hazardous medical condition exists;
- (2) The nature of the procedure requires hospitalization or;
- (3) Other factors (e.g. behavioral problems due to mental impairment) necessitate hospitalization.

(g) **Special Procedures.** Certain procedures rendered in a designated area of a licensed hospital dedicated to specific procedures (i.e, Cardiac Catheterization Lab, etc.) are covered and are not paid at a bundled rate. When multiple APC procedures are performed in the same visit, payment will be the rate of the procedure in the highest payment group.

317:30-5-42.15. Outpatient hospital services for members infected with tuberculosis

Outpatient hospital services are covered for members infected with tuberculosis. Coverage includes, but may not be limited to, outpatient hospital visits, laboratory work and x-rays.

(1) Services to members infected with TB are not limited to the scope of the SoonerCare program; however, prior authorization is required for services that exceed the scope of coverage under SoonerCare.

(2) Drugs prescribed for the treatment of TB not in accordance with OAC 317:30-3-46 require prior authorization by the OHCA Pharmacy Helpdesk using form "Petition for TB Related Therapy."



**317:30-5-42.16. Related services**

(a) Ambulance. Ambulance services furnished by the facility are covered separately if otherwise compensable under the Authority's Medical Programs.

(b) Home health care. Hospital based home health providers must be Medicare certified and have a current Home Health Agency contract with the OHCA.

(1) Payment is made for home health services provided in a member's residence to all categorically needy individuals.

(2) Payment is made for a maximum of 36 visits per year for eligible members 21 years of age or older. Payment for any combination of skilled and home health aide visits can not exceed 36 visits per year.

(3) Payment is made for standard medical supplies.

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

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

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

(A) Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is considered most appropriate.

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

(C) Sterile tracheotomy trays are covered.

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

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

**OAC 317:30-5-42.16 (p2)**

(E) Payment is made for hyperalimentation, including supplements, supplies and equipment rental in behalf of persons having permanently inoperative internal body organ dysfunction. Information regarding the member's medical condition that necessitates the hyperalimentation and the expected length of treatment, should be attached when requesting prior authorization.

(F) Payment is made for ventilator equipment and supplies when prior authorized.

(G) Payment for medical supplies, oxygen, and equipment is made when using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.

(c) **Hospice Services.** Hospice is defined as palliative and/or comfort care provided to the member family when a physician certifies that the member has a terminal illness and has a life expectancy of six months or less. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

(1) Payment is made for home based hospice services for terminally ill individuals under the age of 21 with a life expectancy of six months or less when the member and/or family has elected hospice benefits in lieu of standard SoonerCare services that have the objective to treat or cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family.

(2) Hospice care is available for two initial 90-day periods and an unlimited number of subsequent 60-day periods during the remainder of the member's lifetime. However, the member and/or the family may voluntarily terminate hospice services.

(3) Hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the member is terminally ill must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness.

(4) Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.



**317:30-5-42.17. Non-covered services**

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage:

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

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

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

(4) Medical services considered to be experimental.

(5) Payment for removal of benign skin lesions unless medically necessary.

(6) Refractions and visual aids.

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



**317:30-5-42.18. Coverage for children**

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

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



**317:30-5-47. Reimbursement for inpatient hospital services**

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 SoonerCare members 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 SoonerCare member=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 a threshold amount 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 a percentage of the cost after the 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 72hours 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 members of

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

**OAC 317:30-5-47 (p2)**

the Oklahoma SoonerCare 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) 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 SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.

(8) New providers entering the SoonerCare 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.

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

**OAC 317:30-5-47.1**

---

**317:30-5-47.1. Reimbursement for newborn screening services  
provided by the OSDH**

Newborn screening performed by the Oklahoma State Department of Health in accordance with State Law is excluded from the inpatient DRG payment.



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

**OAC 317:30-5-47.2**

**317:30-5-47.2 Disproportionate share hospitals (DSH)**

Payment will be made to hospitals qualifying for Disproportionate Share Hospital adjustments pursuant to the methodology described in the Oklahoma Title XIX Inpatient Hospital State Plan.



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

**OAC 317:30-5-47.3**

**317:30-5-47.3 Indirect medical education (IME) adjustment**

Payment will be made to hospitals qualifying for Indirect Medical Education payment adjustments pursuant to the methodology described in the Oklahoma Title XIX Inpatient Hospital State Plan.



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

**OAC 317:30-5-47.4**

---

**317:30-5-47.4 Direct medical education payment adjustment**

Payment will be made to hospitals qualifying for Direct Medical Education payment adjustments pursuant to the methodology described in the Oklahoma Title XIX Inpatient Hospital State Plan.



**317:30-5-50. Abortions**

(a) Payment is made only for abortions in those instances where the abortion is necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, or where the pregnancy is the result of an act of rape or incest. SoonerCare coverage for abortions to terminate pregnancies that are the result of rape or incest are considered to be medically necessary services and federal financial participation is available specifically for these services.

(1) For abortions necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, the physician must certify in writing that the abortion is being performed due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. The mother's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.

(2) For abortions in cases of rape or incest, there are two requirements for the payment of a claim. First, the patient must fully complete the Patient Certification For Medicaid Funded Abortion. Second, the patient must have made a police report or counselor's report of the rape or incest. In cases where an official report of the rape or incest is not available, the physician must certify in writing and provide documentation that in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the requirement. The statement explains the reason the rape or incest was not reported. The mother's name and address must be included in the certification and the certification must be signed and dated by the physician. In cases where a physician provides certification and documentation of a client's inability to file a report, the Authority will perform a prepayment review of all records to ensure there is sufficient documentation to support the physician's certification.

(b) The Oklahoma Health Care Authority performs a look-behind

procedure for abortion claims paid from SoonerCare funds. This procedure will require that this Agency obtain the complete medical records for abortions paid under SoonerCare. On a post payment basis, this Authority will obtain the complete medical records on all claims paid for abortions.

(c) Claims for spontaneous abortions, including Dilation and Curettage do not require certification. The following situations also do not require certification:

(1) If the physician has not induced the abortion, counseled or otherwise collaborated in inducing the abortion, and

(2) If the process has irreversibly commenced at the point of the physician's medical intervention.

(d) Claims for the diagnosis incomplete abortion require medical review. The appropriate diagnosis codes should be used indicating spontaneous abortion, etc.; otherwise the procedure will be denied.

**317:30-5-56. Utilization review**

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. In addition to the random sample of all admissions, retrospective review policy includes the following:

(1) Hospital stays less than three days in length will be reviewed 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.

(2) Cases which indicate transfer from one acute care hospital to another will be monitored to help ensure that payment is not made for inappropriate transfers.

(3) Readmissions occurring within 15 days of prior acute care admission for a related condition will be reviewed 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.



**317:30-5-57. Notice of denial**

**(a) General.** 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 SoonerCare member. 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.

**(b) Reconsideration request.** All inpatient stays and outpatient observation services are subject to post-payment utilization review by the OHCA's designated Quality Improvement Organization (QIO). These reviews are based on severity of illness and intensity of treatment. It is the policy and intent of OHCA to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay or outpatient observation of a SoonerCare member. If the QIO, upon their initial review determines the admission or outpatient observation services should be denied, a notice is issued to the facility and the attending physician advising them of the decision. This notice also advises that a reconsideration request may be submitted within the specified time frame on the notice and consistent with the Medicare guidelines. Additional information submitted with the reconsideration request is reviewed by the QIO that utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, the QIO sends written notification of the denial decision to the hospital, attending physician and the OHCA. Once the OHCA has been notified, the overpayment is processed as per the final denial determination.

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

**(d) Patient liability.** If an OHCA, or its designated agent, review results of a denial and the denial is upheld throughout the appeal process and refund from the hospital and physician is required, the

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

OAC 317:30-5-57 (p2)

member cannot be billed for the denied services.

(1) If a hospital or physician believes that an acute care hospital admission or continued stay is not medically necessary and thus not compensable but the member insists on treatment, the member should be informed in writing that he/she will be personally responsible for all charges.

(2) If a claim is filed and paid and the service is later denied the member is not responsible.

**317:30-5-335. Eligible providers**

To be eligible for reimbursement, all ambulance service suppliers that operate air, water or ground services (including stretcher service) must be licensed by the State Department of Health (OSDH) consistent with the level of care they provide, in accordance with the Oklahoma Emergency Response System Development Act of 2005, 63 OS 1-2503. Ambulance suppliers that do not provide services in Oklahoma must be licensed by the appropriate agency in the state in which they provide services. Ambulance companies and all other transportation providers must have a current contract on file with the Oklahoma Health Care Authority (OHCA). Air Ambulance providers must indicate on the application for enrollment that they are requesting fixed wing or rotary wing ambulance status and provide a copy of their license with their enrollment application.



**317:30-5-335.1. Definitions**

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

"Ambulance" means a motor vehicle, watercraft, or aircraft that is primarily used or designated as available to provide transportation and basic life support or advanced life support.

"Bed confined" means that the member is unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair. The term bed confined is not synonymous with bed rest or non-ambulatory.

"Continuous or round trip" means an ambulance service in which the member is transported to the hospital, the physician deems it medically necessary for the ambulance to wait, and the member is then transported to a more appropriate facility for care or back to the place of origin.

"Emergency transfer" means the movement of an acutely ill or injured member from the scene to a health care facility (pre-hospital), or the movement of an acutely ill or injured member from one health care facility to another health care facility (inter-facility).

"Loaded mileage" means the number of miles for which the member is transported in the ambulance.

"Locality" means the service area surrounding the facility from which individuals normally travel or are expected to travel to seek medical care.

"Medically necessary transport" means an ambulance transport that is required because no other effective and less costly mode of transportation can be used due to the member's medical condition. The transport is required to transfer the member to and/or from a medically necessary service not available at the primary location.

"Nearest appropriate facility" means that the receiving institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or physician

**MEDICAL PROVIDERS-FEE FOR SERVICE  
TRANSPORTATION BY AMBULANCE SPECIFIC**

OAC 317:30-5-335.1 (p2)

specialist is available to provide the necessary care required to treat the member's condition. The fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a member of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

"Non-emergency transfer" means the movement of any member in an ambulance other than an emergency transfer.

"Stretcher service" means a non-emergency transport by a ground vehicle that is approved by the OSDH which is designed and equipped to transport individuals on a stretcher or gurney type apparatus that is operated to accommodate an incapacitated or disabled person who does not require medical monitoring, aid, care or treatment during transport.

**317:30-5-336. General coverage**

OHCA covers ground and air ambulance transportation services, within certain limitations.

(1) Ambulance and stretcher transportation is covered only when medically necessary and when due to the member's condition any other method of transportation is contraindicated.

(2) As a general rule ambulance transportation to the nearest appropriate facility in the locality is covered. OHCA utilizes the locality areas as defined by Medicare.

(b) OHCA recognizes different levels of ambulance medical services by qualified ambulance staff according to the standards established by law and regulation through the Oklahoma Emergency Response System Development Act of 2005, '63 OS 1-2503.

(c) Ambulance medical services are divided into different levels for payment purposes. Payment is made according to the medically necessary services actually furnished. That is, payment is based on the level of service furnished, not simply on the vehicle used.

(d) Ambulance providers must maintain documentation of the medical necessity and appropriateness of service in the member's file.

(e) Clinical decisions can be made without delay if documentation to support coverage and medical necessity is submitted as part of the initial claim form. This may be accomplished by submitting supporting detailed documentation regarding the member's condition and need for ambulance/stretcher transport.



**317:30-5-336.1. Medical necessity**

(a) The member's condition must require the ambulance/stretchers transportation itself and the level of service provided, in order for the billed service to be considered medically necessary. Medical necessity is established when the member's condition is such that the use of any other method of transportation is contraindicated.

(b) The medical personnel in attendance, including the Emergency Medical Technician (EMT) at the scene of an emergency, determine medical necessity and appropriateness of service within the scope of accepted medical practice and SoonerCare guidelines.

(c) Non-emergency transports are not covered unless the member is bed confined or has a medical condition that requires medical expertise not available with a less specialized method of transportation. Medical necessity for non-emergency transports must be substantiated with a physician's written order.



**317:30-5-336.2. Nearest appropriate facility**

(a) OHCA covers transportation to the nearest facility that can appropriately treat the member.

(b) An institution is not considered an appropriate facility if the member's condition requires a higher level of care or specialized services available at the more distant hospital. However, a legal impediment barring a member's admission would mean that the institution did not have "appropriate facilities". For example, the nearest transplant center may be in another state and that state's law precludes admission of nonresidents.

(c) An institution is not considered an appropriate facility if no bed is available. However, the medical records must be properly documented.



**317:30-5-336.3. Destination**

(a) Transportation is covered from the point of origin to the Hospital, Critical Access Hospital or Nursing Facility that is capable of providing the required level and type of care for the member.

(b) Ambulance transportation from a hospital with a higher level of care to a hospital with a lower level of care in the locality is covered, provided all other criteria are met and approved by the OHCA.

(c) Non-emergency transportation to the outpatient facilities of a Hospital, free-standing Ambulatory Surgery Center (ASC), Independent Diagnostic Testing Facility (IDTF), Physician's office or other outpatient facility is compensable if the member's condition necessitates ambulance or stretcher transportation and all other conditions are met.

(d) Ambulance Transportation to a Veteran's Administration (VA) Hospital is covered when the trip has not been authorized by the VA.



**317:30-5-336.4. Transport outside of locality**

(a) If ambulance transportation is provided out of the transport locality, the claim must be documented with the reason for the transport outside of the service area.

(b) If it is determined the member was transported out of locality and the closest facility could have cared for the member, payment will be made only for the distance to the nearest medical institution with the appropriate facilities.



**MEDICAL PROVIDERS-FEE FOR SERVICE  
TRANSPORTATION BY AMBULANCE SPECIFIC**

**OAC 317:30-5-336.5**

**317:30-5-336.5 Levels of ambulance service, ambulance fee schedule and base rate**

(a) In accordance with the Oklahoma Emergency Response System Development Act of 2005, '63 OS 1-2503, a license may be issued for basic life support, intermediate life support, paramedic life support, specialized mobile intensive care units, or stretcher aid vans.

(b) Effective October 1, 2005, the OHCA adopted the Medicare Ambulance Fee Schedule (AFS).

(1) The ambulance provider bills one base rate procedure. Levels of service base rates are defined at 42 CFR 414.605.

(2) The base rate must reflect the level of service rendered, not the type of vehicle in which the member was transported, except in those localities where local ordinance requires Advanced Life Support (ALS) as the minimum standard of service.



**MEDICAL PROVIDERS-FEE FOR SERVICE  
TRANSPORTATION BY AMBULANCE SPECIFIC**

**OAC 317:30-5-336.6**

---

**317:30-5-336.6. Mileage**

(a) Charges for mileage must be based on loaded mileage only, i.e., from the pickup of a member to his/her arrival at the destination.

(b) Coverage is allowed only to the nearest appropriate facility.



**317:30-5-336.7. Waiting time**

(a) Waiting time is reimbursable after the first 30 minutes when a physician deems it medically necessary for the ambulance provider to wait at a hospital while the member is being stabilized, with the intent of continuing the member's transport to an appropriate hospital for care or back to the point of origin.

(b) The maximum number of hours allowed for waiting time is four hours.



**317:30-5-336.8. Special situations**

**(a) Continuous or round trip transport.**

(1) If a member is transported to a destination and returned to their original point of pickup, coverage includes payment for the primary transport and the return transport.

(2) If the provider is required to remain and attend the member between transports, the provider may claim waiting time.

**(b) Nursing facility.**

(1) Ambulance or stretcher transportation from nursing home to nursing home (skilled or intermediate care) is covered if the discharging institution is not certified and the admitting nursing home is certified.

(2) Nursing home to nursing home transports are covered if the member requires care not available at the discharging facility, and the member's medical status requires ambulance transport.

**(c) Multiple members per transport.**

(1) When more than one eligible member is transported at the same time, the only acceptable duplication of charges is half the base rate.

(2) Separate claims must be submitted for each member.

(3) No mileage or waiting time is to be charged for additional members. These services are included in the reimbursement of the first claim.

**(d) Multiple transports per member.** More than one transport per member on the same date of service is covered when the member received a different level of service on each transport (e.g., Advanced Life Support 1 and Basic Life Support). When more than one transport with the same level of care occurs on the same day medical necessity must be documented.

**(e) Multiple arrivals.** When multiple units respond to a call for services, only the entity that actually provides services for the member may bill and be paid for the services by the OHCA. The entity that rendered service/care bills for all services furnished.

**MEDICAL PROVIDERS-FEE FOR SERVICE  
TRANSPORTATION BY AMBULANCE SPECIFIC**

**OAC 317:30-5-336.8 (p2)**

(f) **No transport.** If member refuses treatment after immediate aid has been provided the ambulance may bill the base rate for the level of service and waiting time.

(g) **Pronouncement of death.**

(1) If the member dies before dispatch, no payment is available.

(2) If the member dies after dispatch, but before the member is loaded, payment is allowed for the base rate but no mileage.

(3) If the member dies after pickup, payment is available for the base rate and mileage.

(4) Time of death is the point at which the member is pronounced dead by an individual authorized by the state to make such pronouncements.

(h) **Out of state transports.**

(1) Out of state, non-emergency transports require prior authorization.

(2) The ambulance provider, home health agency, hospital, nursing facility, physician, case manager or social worker may request this authorization. The ambulance provider must retain the physician's order of medical necessity in the member's file to support the need for ambulance transportation.

(3) When a member is transported by ground ambulance to or from an air ambulance for out-of-state services, the ground and air ambulance providers providing the transports must bill OHCA independently. When the OHCA is unable to contract for the out-of-state ground transport, the ground and air ambulance charges (air service, medical team, ground transportation) may be consolidated and billed when the following conditions apply.

(A) The air ambulance provider furnishing air transportation (hereafter referred to as "the entity") arranges for ground transportation services and has a contract on file with the OHCA to subcontract for ground ambulance;

(B) The contract includes the requirement that the entity certifies that the ground transportation provider meets the

minimum state licensure requirements in the state in which the service is provided;

(C) The entity certifies that the payment will be made to the ground provider;

**(i) Neonatal transports.**

(1) Coverage of neonatal transport includes neonatal base rate, loaded mileage, transfer isolette, and waiting time.

(2) The intensive care transport of critically ill neonate(s) (i.e. newborns to approved, designated neonatal intensive care units) is a covered service.

(3) When a trained hospital medical team from the receiving or transferring hospital accompanies a newborn on the transport ambulance services, the primary care of the newborn is the hospital team's responsibility, reimbursement for the hospital team is made to the hospital as part of the hospital rate.



**317:30-5-336.9. Air ambulance**

(a) Air Ambulance service, which includes fixed and rotary wing transportation, are covered only when:

(1) The point of pickup is inaccessible by land vehicle; or,

(2) Great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate facilities and timely admission is essential; i.e., in cases where transportation by land ambulance is contraindicated; or

(3) The member's medical condition and other circumstances of the case necessitated the use of this type of transportation. However, where land ambulance service would have sufficed, payment is based on the amount payable for land ambulance, if this is less costly.

(b) Only one base rate is allowed per trip. Base rate includes the lift off, professional intensive care, transport isolate, ventilator setup, respiratory setup, and all other medical services provided during the flight. No additional payment is made to the air service provider for bedside to bedside service.

(c) If the accident scene is inaccessible by air and a land ambulance must pick up the member to transport to a site where the air ambulance can land, the land ambulance trip is covered. Air transportation is covered only to a hospital in this situation.



**317:30-5-336.10. Fixed wing air ambulance services**

(a) Fixed wing air ambulance transports must be prior authorized.

(b) Ambulance transport in a fixed wing aircraft is a covered service if the following requirements are met:

(1) The transport, including ancillary services (e.g. flight nurse), is ordered by a physician.

(2) The written physician order is maintained in the members file.

(3) Transport by ground vehicle would endanger the member's life due to time and distance from the hospital.

(4) Medically necessary care or services for the member's medical condition cannot be provided by a local facility.



**317:30-5-336.11. Rotary wing air ambulance**

Rotary wing air ambulance services are covered by the OHCA only under the following circumstances:

(1) Time and distance in a ground ambulance would be a hazard to the life of the member;

(2) The medically necessary care and services for the member's need are not available at the local hospital, and;

(3) The transfer is for medical or surgical procedures, not solely for diagnostic services only.



**317:30-5-336.12. Non-emergency ambulance and stretcher service transportation**

(a) OHCA covers non-emergency ground, stretcher and air transportation to and from a medically necessary service. To be covered, the member must be either:

(1) bed confined and unable to use another means of transportation, or

(2) the member's condition must warrant ambulance transportation.

(b) OHCA's Non-emergency Transportation (NET) program, known as SoonerRide, is the first choice for non-emergency transportation for scheduled medical services. SoonerRide provides non-emergency transportation in accordance with all applicable criteria set forth in the American's with Disabilities Act (ADA).

(c) Regularly scheduled non-emergency medical services, such as outpatient dialysis, must be scheduled through SoonerRide unless the member's condition requires transport by stretcher or ambulance. All claims for scheduled trips for outpatient services that cannot be provided by SoonerRide must be accompanied by the medical documentation to substantiate the need for the higher level of transportation and will be reviewed prior to payment by OHCA.

(d) Ambulance or stretcher transport for unscheduled emergent medical care is covered if the trip meets all applicable criteria.



**317:30-5-336.13. Non covered services**

(a) Transportation by ambulance is not covered when the member's condition did not require that level of transportation and another mode of transportation would suffice.

(b) Ambulance transportation from residence to residence is not covered except for transfers from nursing home to nursing home when the transferring facility is not certified.

(c) Payment will not be made for ambulance transportation determined not to be medically necessary.

(d) Transportation to a funeral home, mortuary, or morgue is not covered.



**317:30-5-337. Coverage for children**

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

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



**MEDICAL PROVIDERS-FEE FOR SERVICE  
TRANSPORTATION BY AMBULANCE SPECIFIC**

**OAC 317:30-5-339**

---

**317:30-5-339. Individuals eligible for Part B of Medicare**

Payment for ambulance transportation is made using current Medicare methodology.



**317:30-5-545. Eligible providers**

All eligible home health service providers must be Medicare certified, accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), or have deemed status with Medicare, and have a current contract with the Oklahoma Health Care Authority. Home Health Agencies billing for durable medical equipment (DME) must have a supplier contract and bill equipment on claim form CMS-1500. Additionally, home health services providers that did not participate in Medicaid prior to January 1, 1998, must meet the "Capitalization Requirements" set forth in 42 CFR 489.28.

Home health services providers that do not meet these requirements will not be permitted to participate in the Medicaid program.



**317:30-5-566. 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.

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

(A) Nursing, technicians, 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.

(B) Use by the member 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.

(C) 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 member is in the facility. Surgical dressings, other supplies, splints, and casts include only 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 member and facility personnel, i.e., gowns, masks, drapes, hoses, scalpels, etc., whether disposable or reusable.

(D) Diagnostic or therapeutic items and services directly related to the surgical procedures. 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.

(E) 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.

(F) Blood, blood plasma, platelets, etc. Under normal circumstances, blood and blood fractions 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.

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

**(2) Services not included in facility reimbursement rates are:**

(A) Physicians' services. This category includes most services performed in the facility which are not considered facility services. The term physicians' services includes any pre/post-operative 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.

(B) The sale, lease or rental of durable medical equipment (DME) to members for use in their homes. If the facility furnishes items of DME to members it should be treated as a DME supplier and this requires a separate contract and separate claim form. Coverage of DME is limited to the scope of the Authority's Medical Programs.

(C) 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 prostheses is intra ocular lenses (IOL's). These should be billed as a separate line item.

(D) Ambulance services. If the facility furnishes ambulance services, they are covered separately as ambulance services if otherwise compensable under the Authority's Medical Programs. This requires a separate contract and a separate claim form.

(E) 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.

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

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

(H) 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 as adapted for SoonerCare.

(3) **Compensable procedures.** The List of Covered Surgical Procedures in (1) of this Section sets out those procedures for which the Authority will recognize a facility charge if otherwise compensable under the Authority's Medical Programs. If a procedure code is not on the list the Authority will not pay a facility charge.

(A) The inclusion of a procedure on this list does not in any way change any of the overall coverage limitations or exclusions of the SoonerCare program. For instance, the program generally excludes coverage for cosmetic surgery, and sexual reassignment. This list sets out the coverage and payment provisions if the procedure is otherwise compensable.

(B) The procedures are listed by body system, HCPCS codes, a brief description of the procedure and the applicable group payment rate.

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



Payment is made for ambulatory surgical center services as set forth in this Section.

(1) **Children.** Payment is made for children for medically necessary surgical procedures which are included on the List of Covered Surgical Procedures.

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

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

(2) **Adults.** Payment is made for adults for medically necessary surgical procedures which are included on the List of Covered Surgical Procedures.

(3) **Individuals eligible For Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services.