
POLICY TRANSMITTAL NO. 06-57	DATE: JANUARY 17, 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 317:30-3-57; 30-3-59; 30-5-12; 30-5-24; 30-5-137 through 30-5-141; 30-5-226; 30-5-355.1; 30-5-361; 30-5-466; 30-5-467; 30-5-556; 30-5-558; 30-5-560 through 30-5-560.2; 30-5-901; and 35-21-12.

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

Rules are issued to establish coverage for bariatric surgery for members of ages eighteen to sixty-five with a body mass index of thirty-five or greater who have been diagnosed with one of the following conditions, diabetes mellitus, degenerative joint disease of at least one major weight bearing joint or have another co-morbid condition.

Rules are revised to: establish specific time frames in which a member has to seek diagnostic testing and treatment for breast and cervical cancer (BCC); allow mammograms for members of any age or gender when they are medically indicated as necessary; and add private duty nursing services to assist in transporting members to medical appointments and emergency room visits within the approved hours in the treatment plan and to require a new or revised treatment plan, signed by the physician, at least annually.

Original signed on 1-12-07

Mary Stalnaker, Director
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WF # 06-Z (DT)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

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

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

REMOVE

INSERT

317:30-3-57	317:30-3-57, pages 1-7, revised 12-1-06
317:30-3-59	317:30-3-59, pages 1-2, revised 12-1-06
317:30-5-12	317:30-5-12, 1 page only, revised 12-1-06
317:30-5-24	317:30-5-24, pages 1-2, revised 12-1-06
317:30-5-137	317:30-5-137, 1 page only, issued 10-8-06
317:30-5-138	317:30-5-138, pages 1-2, issued 10-8-06
317:30-5-139	317:30-5-139, 1 page only, issued 10-8-06
317:30-5-140	317:30-5-140, 1 page only, issued 10-8-06
317:30-5-141	317:30-5-141, 1 page only, issued 10-8-06
317:30-5-226	317:30-5-226, 1 page only, revised 12-1-06
317:30-5-355.1	317:30-5-355.1, pages 1-5, revised 12-1-06
317:30-5-361	317:30-5-361, pages 1-2, revised 12-1-06
317:30-5-466	317:30-5-466, pages 1-3, revised 12-1-06
317:30-5-467	317:30-5-467, 1 page only, revised 12-1-06
317:30-5-556	317:30-5-556, 1 page only, revised 12-1-06
317:30-5-558	317:30-5-558, pages 1-2, revised 12-1-06

REMOVE

317:30-5-560

317:30-5-560.1

317:30-5-560.2

317:30-5-901

317:35-21-12

INSERT

317:30-5-560, pages 1-2, revised 12-1-06

317:30-5-560.1, 1 page only, revised 12-1-06

317:30-5-560.2, 1 page only, revised 12-1-06

317:30-5-901, 1 page only, revised 12-1-06

317:35-21-12, pages 1-2, revised 10-8-06

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare coverages for the categorically needy:

(1) Inpatient hospital services other than those provided in an institution for mental diseases.

(A) Adult coverage for inpatient hospital stays as described at OAC 317:30-5-41.

(B) Coverage for members under 21 years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or free standing dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with OHCA.

(6) Outpatient Mental Health Services for medical and remedial care including services provided on an outpatient basis by certified hospital based facilities that are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.

(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.

(9) Maternity Clinic Services.

(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.

(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.

(12) Nursing facility services (other than services in an institution for tuberculosis or mental diseases).

(13) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under 21 years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA Child Health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.4.

(A) Child health screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.

(C) Immunizations.

(D) Outpatient care.

(E) Dental services as outlined in OAC 317:30-3-65.8.

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one visual screening and glasses each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected.

(G) Hearing services as outlined in OAC 317:30-3-65.9.

(H) Prescribed drugs.

(I) Outpatient Psychological services as outlined in OAC 317:30-5-275 through OAC 317:30-5-278.

(J) Inpatient Psychotherapy services and psychological testing as outlined in OAC 317: 30-5-95 through OAC 317:30-5-97.

(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.

(L) Inpatient hospital services.

(M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of SoonerCare.

(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members 21 years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least 30 days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Family planning centers.

(16) Physicians' services whether furnished in the office, the member's home, a hospital, a nursing facility, ICF/MR, or elsewhere. For adults, payment is made for up to the limited number of compensable hospital days described at OAC 317:30-5-41. These days will be maintained on the recipient record. Physician claims for hospital visits will be paid until the last compensable hospital day is captured. After the limited number of hospital days have been captured, inpatient physician services will not be paid beyond the last compensable hospital day. Office visits for adults are limited to four per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

(17) Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. See applicable provider section for limitations to covered services for:

- (A) Podiatrists' services
- (B) Optometrists' services
- (C) Psychologists' services
- (D) Certified Registered Nurse Anesthetists
- (E) Certified Nurse Midwives
- (F) Advanced Practice Nurses

(18) Free-standing ambulatory surgery centers.

(19) Prescribed drugs not to exceed a total of six prescriptions with a limit of three brand name prescriptions per month. Exceptions to the six prescription limit are:

- (A) unlimited medically necessary monthly prescriptions for:
 - (i) members under the age of 21 years; and
 - (ii) residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded.

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

(20) Rental and/or purchase of durable medical equipment.

(21) Adaptive equipment, when prior authorized, for members residing in private ICF/MR's.

(22) Dental services for members residing in private ICF/MR's in accordance with the scope of dental services for members under

age 21.

(23) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.

(24) Standard medical supplies.

(25) Eyeglasses under EPSDT for members under age 21. Payment is also made for glasses for children with congenital aphakia or following cataract removal.

(26) Blood and blood fractions for members when administered on an outpatient basis.

(27) Inpatient services for members age 65 or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.

(28) Nursing facility services, limited to members preauthorized and approved by OHCA for such care.

(29) Inpatient psychiatric facility admissions for members under 21 are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.

(30) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.

(31) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last date of pregnancy.

(32) Nursing facility services for members under 21 years of age.

(33) Personal care in a member's home, prescribed in accordance

with a plan of treatment and rendered by a qualified person under supervision of a R.N.

(34) Part A deductible and Part B medicare Coinsurance and/or deductible.

(35) Home and Community Based Waiver Services for the mentally retarded.

(36) Home health services limited to 36 visits per year and standard supplies for 1 month in a 12-month period. The visits are limited to any combination of Registered Nurse and nurse aide visits, not to exceed 36 per year.

(37) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

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

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

(C) 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.

(D) Finally, procedures considered experimental or investigational are not covered.

(38) Home and community-based waiver services for mentally retarded members who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).

(39) Case Management services for the chronically and/or severely mentally ill.

(40) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.

(41) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.

- (42) Early Intervention services for children ages 0-3.
- (43) Residential Behavior Management in therapeutic foster care setting.
- (44) Birthing center services.
- (45) Case management services through the Oklahoma Department of Mental Health and Substance Abuse.
- (46) Home and Community-Based Waiver services for aged or physically disabled members.
- (47) Outpatient ambulatory services for members infected with tuberculosis.
- (48) Smoking and Tobacco Use Cessation Counseling for children and adults.
- (49) Services delivered to American Indians/Alaskan Natives in I/T/Us. Payment is made on an encounter basis.

317:30-3-59. General program exclusions - adults

The following are excluded from Medicaid coverage for adults:

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

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

(3) Services of two physicians for the same type of service to the same patient 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 patient's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the patient's care, the codes for subsequent hospital care should be used.

(4) Refractions and visual aids.

(5) Separate payment for pre and post-operative care when payment is made for surgery.

(6) Reversal of sterilization procedures for the purposes of conception.

(7) Non therapeutic hysterectomies. Therapeutic hysterectomies require that the following information to be attached to the claim:

(A) a copy of an acceptable acknowledgment form signed by the patient, or,

(B) an acknowledgment by the physician that the patient has already been rendered sterile, or,

(C) a physician's certification that the hysterectomy was performed under a life-threatening emergency situation.

(8) 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.

(9) Medical services considered to be experimental.

(10) Services of a Certified Surgical Assistant.

(11) Services of a Chiropractor. Payment is made for Chiropractor services on Crossover claims for coinsurance and/or deductible only.

(12) Services of a Registered Physical Therapist.

(13) Services of a Psychologist.

(14) Services of a Speech and Hearing Therapist.

(15) Payment for more than four outpatient visits per month (home, office, outpatient hospital) per patient, except those visits in connection with family planning or emergency medical condition.

(16) Payment for more than two nursing home visits per month.

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

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

317:30-5-12. Family planning

(a) Pregnancy tests are covered.

(b) Reverse vasectomy is not covered.

(c) Reversal of sterilization procedures for the purpose of conception are not covered.

317:30-5-24. Radiology

(a) **Outpatient and emergency department.**

(1) The technical component of outpatient radiological services performed during an emergency department visit is included in the emergency department all inclusive payment rate on a per visit basis which is paid to the hospital.

(2) The professional component of x-rays performed during an emergency department visit is covered.

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

(4) 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).

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

(b) **Inpatient procedures.** Inpatient radiological procedures are compensable if done on a referral basis. Claims for inpatient interpretations by the attending physician are not compensable unless the attending physician reads interpretations for the hospital on all patients.

(c) **Inpatient radiology performed outside of hospital.** When a member is an inpatient but has to be taken elsewhere for an x-ray, such as to an office or another hospital because the admitting hospital did not have proper equipment, the place of service must still be inpatient hospital, since the member is considered to be in the hospital at the time of service.

(d) **Radiology therapy management.** Weekly clinical management is based on five fractions delivered comprising one week regardless of the time interval separating the delivery of treatments. Weekly clinical management must be billed as one unit of service rather than five.

(e) **Miscellaneous.**

(1) **Arteriograms, angiograms and aortograms.** When arteriograms, angiograms or aortograms are performed by a radiologist, they are considered radiology, not surgery.

(2) **Injection procedure for arteriograms, angiograms and aortograms.** The "interpretation only" code and the "complete procedure" code are not both allowed for one of these procedures.

(3) **Evac-U-Kit or Evac-O-Kit.** Evac-U-Kit and Evac-O-Kit are included in the charge for the Barium Enema.

(4) **Examination.** Examination at bedside or in operating room allows an additional charge to be made. Examination outside regular hours is not a covered charge.

(5) **Supplies.** Separate payment is not made for supplies such as "administration set" used in provision of office chemotherapy.

(6) **Fluoroscopy or Esophagus study.** Separate charge for fluoroscopy or esophagus study in addition to a routine gastrointestinal tract examination is not covered unless a report is submitted indicating an esophagram was done as a separate procedure.

(f) **Magnetic Resonance Imaging.** MRI/MRA scans are covered when medically necessary. Documentation in the progress notes must reflect the medical necessity. The diagnosis code must be shown on the claim.

(g) **Placement of radium or other radioactive material.**

(1) For Radium Application use the appropriate HCPCS code.

(2) When a physician supplies the therapeutic radionuclides (implant grains or Gold Seeds) and provides a copy of the invoice, payment is made at 100% of the invoice charges. Fee must include cost of radium, container, and shipping and handling.

317:30-5-137. Eligible providers to perform bariatric surgery

The Oklahoma Health Care Authority (OHCA) covers bariatric surgery under certain conditions as defined in this section. Bariatric surgery is not covered for the treatment of obesity alone. To be eligible for reimbursement for bariatric surgery providers must be certified by the American College of Surgeons (ACS) as Level I Bariatric Surgery Center or certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (BSCOE) or the surgeon and facility are currently participating in a bariatric surgery assurance program and a clinical outcomes assessment program. All qualifications must be met and approved by the OHCA. Bariatric surgery facilities and their providers must be contracted with OHCA.

317:30-5-138. General coverage

(a) After determining member requirements are met (see OAC 317:30-5-139) and receiving prior authorization from OHCA, the primary care provider coordinates a process to include:

(1) a comprehensive psychosocial evaluation including:

(A) evaluation for substance abuse;

(B) evaluation for psychiatric illness which would preclude the member from participating in pre-surgical dietary requirements or post surgical lifestyle changes;

(C) if applicable, documentation that the member has been successfully treated for a psychiatric illness and has been stabilized for at least six months; and

(D) if applicable, documentation that the member has been rehabilitated and is free from drug and/or alcohol for a period of at least one year.

(2) an independent medical evaluation performed by an internist who is contracted with the OHCA to assess the member's preoperative and mortality risks.

(3) a surgical evaluation by an OHCA contracted surgeon who has credentials to perform bariatric surgery.

(4) participation in a weight loss program prior to surgery, under the supervision of an OHCA contracted medical provider. The member must, within one hundred and eighty days from the approval of the OHCA's prior authorization, lose at least five percent of member's initial body weight.

(A) If the member does not meet the weight loss requirement in the allotted time the prior authorization is cancelled.

(B) The member's provider must reapply for prior authorization to restart the process if the requirement is not met.

(b) When all requirements have been met, a prior authorization for surgery must be obtained from OHCA.

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OAC 317:30-5-138 (p2)

(c) The bariatric surgery facility or surgeon must, on an annual basis, provide to the OHCA the members statistical data which includes but is not limited to, mortality, hospital readmissions, re-operation, morbidity data and average weight loss.

(d) OHCA considers surgery to correct complications from bariatric surgery medically necessary, such as obstruction or stricture.

(e) OHCA considers repeat bariatric surgery medically necessary for a member whose initial bariatric surgery was medically necessary, and member meets either of the following criteria:

(1) has not lost more than fifty percent of excess body weight two years following the primary bariatric surgery procedure and is in compliance with prescribed nutrition and exercise programs following the procedure; or

(2) revision of a primary bariatric surgery procedure that failed due to dilation of the gastric pouch if the procedure was successful in inducing weight loss prior to the pouch dilation, and is in compliance with prescribed nutrition and exercise programs following the procedure.

(f) OHCA may withdraw authorization of payment for the bariatric surgery at any time if the OHCA determines that the member or provider is not in compliance with any of the requirements.

317:30-5-139. Member requirements

Members must meet the following criteria to be eligible:

- (1) be between 18 and 65 years of age;
- (2) have body mass index (BMI) of thirty-five or greater;
- (3) be diagnosed with one of the following:
 - (A) diabetes mellitus;
 - (B) degenerative joint disease of a major weight bearing joint(s). The member must be a candidate for joint replacement surgery if weight loss is achieved; or
 - (C) a rare co-morbid condition in which there is medical evidence that bariatric surgery is medically necessary and that the benefits of bariatric surgery outweigh the risk of surgical mortality.
- (4) have presence of obesity that has persisted for at least 5 years;
- (5) have attempted weight loss in the past without successful long term weight reduction, which must be documented by a physician;
- (6) have absence of other medical conditions that would increase the member's risk of surgical mortality or morbidity; and
- (7) the member is not pregnant or planning to become pregnant in the next two years.

317:30-5-140. 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 Medicaid 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.

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317:30-5-141. Reimbursement

Payment is made at the lower of the provider's usual and customary charge or the OHCA fee schedule for Medicaid compensable services.

317:30-5-226. Coverage by category

(a) **Adults.** Payment is made for nurse midwife services including management of normal care of the mother and newborn(s) throughout the maternity cycle.

(1) The county OKDHS office where the mother resides must be notified in writing within five days of the child`s birth in order for an individual person code to be assigned to the newborn. A claim may then be filed for charges for the baby under the case number and the baby's name and assigned person code.

(2) Charges billed on the mother's person code will be denied.

(3) Providers must use OKDHS Form FSS-NB-1 to notify the county DHS office of the child's birth.

(4) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care, and any ultrasounds performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider=s care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

(b) **Children.** Payment to nurse midwives for services to children is the same as for adults.

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

317:30-5-355.1. Definition of services

The RHC benefit package, as described in Title 42 of the Code of Federal Regulations (CFR), part 440.20, consists of two components: RHC Services and Other Ambulatory Services.

(1) **RHC services.** RHC services are covered when furnished to a member at the clinic or other location, including the member's place of residence. In all instances where possible, SoonerCare defines a Rural Health Clinic service the same as Medicare as set out in Information Bulletin 93-15 issued by Blue Cross/Blue Shield of Oklahoma, Medicare Part A. These services are described in this Section.

(A) **Core services.** As set out in Federal Regulations at 42 CFR 440.20(b), RHC "core" services include, but are not limited to:

(i) Physician's services;

(ii) Services and supplies incident to a physician's services;

(iii) Services of advanced practice nurses (APNs), physician assistants (PAs), nurse midwives (NMs) or specialized advanced practice nurse practitioners;

(iv) Services and supplies incident to the services of APNs and PAs (including services furnished by nurse midwives);

(v) Visiting nurse services to the homebound;

(vi) Clinical psychologist (CP) and clinical social worker (CSW) services;

(vii) Services and supplies incident to the services of CPs and CSWs; and

(viii) Laboratory tests essential to the immediate diagnosis and treatment of the member including:

(I) chemical examinations of urine by stick or tablet,

(II) hemoglobin or hematocrit,

(III) blood sugar,

(IV) examination of stool specimens for occult blood,

(V) pregnancy tests,

(VI) primary culturing for transmittal to a certified laboratory.

(B) **Physicians' services.** In addition to the professional services of a physician, and services provided by an APN, PA and NMW which would be covered as RHC services under Medicare, certain primary preventive services are covered under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of a RHC practitioner who is a clinic employee:

(i) prenatal and postpartum care;

(ii) screening examination under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for members under 21;

(iii) family planning services;

(iv) medically necessary screening mammography and follow-up mammograms when medically necessary.

(C) **Services and supplies "incident to".** Services and supplies incident to the service of a physician, physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker are covered if the service or supply is:

(i) a type commonly furnished in physicians' offices;

(ii) a type commonly rendered either without charge or included in the rural health clinic's bill;

(iii) furnished as an incidental, although integral, part of a physician's professional services;

(iv) A separate charge is allowable for immunizations

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covered under EPSDT. Also, injections not otherwise discussed below must be billed separately using the appropriate HCPC codes. However, drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(D) **Visiting nurse services.** Visiting nurse services are covered if:

(i) the RHC is located in an area in which the Centers for Medicare and Medicaid Services (CMS) has determined there is a shortage of home health agencies;

(ii) the services are rendered to members who are homebound;

(iii) the member is furnished nursing care on a part time or intermittent basis by a registered nurse, licensed practical nurse or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and

(iv) the services are furnished under a written plan of treatment.

(E) **RHC encounter.** RHC "core" services (including preventive services, i.e., prenatal, EPSDT or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and a RHC health professional (i.e., physicians, physician assistants, advanced practice nurses, nurse midwives, clinical psychologists and clinical social workers). Encounters with more than one health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

(F) **Off-site services.** RHC services provided off-site of the clinic are covered as long as the RHC has a compensation

arrangement with the RHC practitioner that SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The rural health clinic must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the rural health clinic services provided off-site are to be billed to SoonerCare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) **Other ambulatory services.** A Rural Health Clinic must provide other items and services which are not "RHC services" as described in (a)(1) of this Section, and are separately billable to the SoonerCare program. Coverage of services are based upon the scope of coverage under the SoonerCare program.

(A) Other ambulatory services include, but are not limited to:

(i) dental services for members under age 21;

(ii) optometric services;

(iii) clinical lab tests performed in the RHC lab (other than the specific laboratory tests set out for RHC certification and covered as RHC services);

(iv) technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);

(v) durable medical equipment;

(vi) emergency ambulance transportation;

(vii) prescribed drugs;

(viii) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

(ix) specialized laboratory services furnished away from the clinic;

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(x) inpatient services;

(xi) outpatient hospital services.

(B) Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist or optometric services by a licensed optometrist for members under age 21. Encounters are billed as one of the following:

(i) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.

(ii) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.

(iii) **Visual analysis.** Visual analysis (initial or yearly) for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Glasses must be billed separately.

(C) Services listed in (a)(2)(A), (v)-(viii), of this Section, furnished on-site, require separate provider agreements with the OHCA. Service item (a)(2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

(D) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

317:30-5-361. Billing

(a) **Encounters.** Payment is made for one type of encounter per member per day. Rural health clinics must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

(1) **RHC.** The appropriate revenue code is required. No HCPC or CPT code is required.

(2) **Mental health.** Mental health services must include a revenue code and a HCPCS code.

(3) **Obstetrical care.** The appropriate revenue code and HCPCS code are required. The date the member is first seen is required. The primary pregnancy diagnosis code is also required. Secondary diagnosis codes are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.

(4) **Family planning.** Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.

(5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the Current Procedural Terminology Manual (CPT).

(6) **Dental.** Dental services for children must be billed on the appropriate dental claim form.

(7) **Visual analysis.** Optometric services for children are billed using the appropriate revenue code and a HCPCS code.

(b) **Services billed separately from encounters.** Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges.

(1) **Laboratory.** The rural health clinic must be CLIA certified for specialized laboratory services performed. Laboratory services which are not included in the all-inclusive rate must

be itemized separately using the appropriate CPT or HCPCS code.

(2) **Radiology.** Radiology must be identified using the appropriate CPT or HCPC code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.

(3) **Immunizations.** The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.

(4) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required. The following are examples:

(A) DepoProvera 150 mg. (Medroxyprogesterone Acetate).

(B) Insertion and implantation of a subdermal contraceptive device.

(C) Removal, implantable contraceptive devices.

(D) Removal, with reinsertion, implantable contraceptive device.

(E) Insertion of intrauterine device (IUD).

(F) Removal of intrauterine device.

(G) ParaGard IUD.

(H) Progestasert IUD.

(5) **Glasses.** Glasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code.

317:30-5-466. Coverage by category

Payment is made to family planning centers as set forth in this Section.

(1) **Adults.** Payment is made for adults on an encounter basis. Each encounter is all inclusive of the following and payment includes all services provided:

(A) **Initial examination services.** Initial examination services that are provided to new family planning patients include:

(i) Complete physical examination including assessment of height, weight, blood pressure, thyroid, extremities, heart, lungs, breasts, abdomen, pelvic examination, including visualization of the cervix, external genitalia, bimanual exam, and rectal exam as indicated. (Male clients receive examination of genitals and rectum including palpation of the prostate in lieu of pelvic exam given females.)

(ii) Complete general history of patient and pertinent history of immediate family members. This general history addresses allergies, immunizations, past illnesses, hospitalizations, surgery, review of systems, use of alcohol, tobacco and drugs. Reproductive function history in female patients includes menstrual history, sexual activity, sexually transmitted diseases, contraceptive use, pregnancies, and in utero exposure to DES. Male reproductive general history includes sexual activity, sexually transmitted diseases, fertility, and exposure to DES.

(iii) Laboratory services to include hematocrit, dip stick urinalysis, pap smear, gonorrhea culture, serologic test for syphilis and rubella screening if indicated.

(iv) Education and counseling are offered to provide information regarding reproductive anatomy, range of clinic services, risks benefits and side effects of various methods of contraception, and health promotion/disease prevention topics as needed.

(v) Provision for an annual supply of chosen contraceptive

method to include, but not limited to, injections (administration and medication), oral contraceptive, IUD, diaphragm, foam, condoms or natural family planning.

(vi) Treatment of minor gynecological problems, infections, and other conditions.

(vii) Referral to appropriate providers for problems or conditions which are beyond the scope of the clinic to treat.

(B) Annual examination services. Annual examination services are provided to continuing patients to include:

(i) Annual update physical examination to include height, weight, blood pressure, extremities, and examination of breasts and pelvic organs. If required, a complete physical examination may be provided as described under the initial visit services above.

(ii) A medical history update is taken to update the general history and includes noting the patient's adaptation to and correct use of contraceptive method, menstrual history, specific warning signs and other side effects related to the contraceptive method. If indicated, a complete general history of the patient will be taken at the annual visit.

(iii) Laboratory services to include pap smear, gonorrhea culture, hematocrit, and serologic test for syphilis.

(iv) Education and counseling regarding specific problems, risks and side effects of the method in use.

(v) Provision for an annual supply of chosen contraceptive method to include, but not limited to, injections (administration and medication), oral contraceptive, IUD, diaphragm, foam, condoms or natural family planning.

(vi) Treatment of minor gynecological problems, infections, and other conditions.

(vii) Referral to appropriate providers for problems or conditions which are beyond the scope of the clinic to treat.

(C) **Encounter visits.**

(i) Encounter visits covers services provided to patients which are not part of the initial/annual examinations. This may include:

(I) A follow-up visit for all new patients to insure they understand and are experiencing no problems with their particular contraceptive method.

(II) A scheduled revisit for a new or continuing patient who may have conditions which places the patient in a high risk category requiring more intensive medical management as outlined in the program medical protocol.

(ii) Encounter visits may also be scheduled at the request of the patient as they are encouraged to return to the clinic at any time they experience difficulty with a particular contraceptive method or have concerns related to their reproductive health. Pregnancy diagnosis and counseling services are also provided under this category.

(D) **Vasectomy.** For vasectomies, payment will be made as an all-inclusive rate for all services provided in connection with the surgery. Claims must have the Federally mandated consent form properly completed and attached.

(E) **Tubal ligations.** For tubal ligations, payment will be made as an all-inclusive rate for the cost of the surgeon, anesthesiologist, pre and post-operative care and outpatient surgery facility. Claims must have the properly completed Federally mandated consent form attached.

(2) **Children.** Payment is made for children as set forth for adults. However payment cannot be made for the sterilization of persons under the age of 21.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Claims for services which are not covered by Medicare should be filed directly with the Fiscal Agent for payment within the scope of the program.

317:30-5-467. Coverage limitations

(a) Sterilizations require proper consent form and are not compensable for patients under 21 years of age.

(b) The following coverage limitations apply to services provided by family planning centers:

(1) Service: Initial Examination; Unit: Completed Examination and Services; Limitation: one initial examination.

(2) Service: Annual; Unit: Completed Examination and Services; Limitation: one annual examination.

(3) Service: Encounter Visit; Unit: Completed Examination and Services; Limitation: one per day.

(4) Service: Vasectomy; Unit: Completed Examination and Services; Limitation: one each (required consent restricted to persons age 21 and over, at time consent form is signed).

(5) Service: Tubal Ligation; Unit: Completed Examination and Services; Limitation: one each (required consent restricted to persons age 21 and over, at time consent form is signed).

317:30-5-556. Definitions

The definition of private duty nursing is medically necessary care provided on a regular basis by a Licensed Practical Nurse or Registered Nurse in the member's residence or to assist outside the home during transport to medical appointments and emergency room visits in lieu of transport by ambulance.

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

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

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

(2) A treatment plan must be completed by the Nursing agency before requesting prior authorization and must be updated at least annually and signed by the physician;

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

(4) Care in excess of the designated hours per day granted in the prior authorization is not Medicaid-compensable. Prior-authorized but unused service hours cannot be "banked," "saved," or otherwise "accumulated" for use at a future date or time. If such hours or service are provided, they are not Medicaid-compensable.

(5) Any care provided outside of the home is limited to assisting during transport to medical appointments and emergency room visits in lieu of transport by ambulance and is limited to the number of hours requested on the treatment plan and approved by OHCA.

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

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

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

(9) OHCA will not approve Private Duty Nursing service if all health and safety issues cannot be met in the home setting.

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(10) A provider must not misrepresent or omit facts in a treatment plan.

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

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

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

317:30-5-560. Treatment Plan

(a) An eligible organization must create a treatment plan for the member as part of the authorization process for private duty nursing services. The initial treatment plan must be signed by the member's attending physician. It must be updated and signed annually.

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

- (1) diagnosis
- (2) prognosis
- (3) anticipated length of treatment
- (4) number of hours of private duty nursing requested per day
- (5) assessment needs and frequency (e.g., vital signs, glucose checks, neuro checks, respiratory)
- (6) medication method of administration and frequency
- (7) age-appropriate feeding requirements (diet, method and frequency)
- (8) respiratory needs
- (9) mobility requirements including need for turning and positioning, and the potential for skin breakdown
- (10) developmental deficits
- (11) casting, orthotics, therapies
- (12) age-appropriate elimination needs
- (13) seizure activity and precautions
- (14) age-appropriate sleep patterns
- (15) disorientation and/or combative issues

- (16) age_appropriate wound care and/or personal care
- (17) communication issues
- (18) social support needs
- (19) name, skill level, and availability of all caregivers
- (20) other pertinent nursing needs such as dialysis, isolation.

317:30-5-560.1. Prior authorization requirements

- (a) Authorizations are provided for a maximum period of six months.
- (b) Authorizations require:
- (1) a treatment plan for the member; and
 - (2) a visit by an OHCA Care Management Nurse to determine medical necessity using the Private Duty Nursing Acuity Grid.
- (c) The number of hours authorized may differ from the hours requested on the treatment plan based on the assessment of the Care Management Nurse.
- (d) If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization.
- (e) Changes in the treatment plan may necessitate another visit by the Care Management staff.

317:30-5-560.2. Record documentation

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

317:30-5-901. Coverage by category

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

(b) **Children.** Coverage for children is the same as for adults.

317:35-21-12. Changes after certification/continued need for treatment

(a) A woman found to be in need of treatment as the result of an abnormal BCC screen has 60 days from the date of the application to complete the initial appointment for a diagnostic procedure and an additional 60 days to complete any additional diagnostic testing required or to initiate compensable treatment for a cancerous or pre-cancerous condition. The exception to the time limit is evidence of a lack of appointment availability. Upon completion of the diagnostic testing, OHCA is provided a medical report of the findings.

(1) If the woman is found not to have breast or cervical cancer including pre-cancerous conditions and early stage, recurrent or metastatic cancer for which she is in need of treatment or fails to have diagnostic testing or begin treatment within the time frames described in OAC 317:35-21-12(a), the case is closed by OKDHS and appropriate notification is computer generated.

(2) If a medical report necessary to determine continued treatment is not received from a provider within ten working days after a request is made by OHCA, the report is considered negative and the case is closed by OKDHS and appropriate notification is computer generated.

(b) If the woman in need of treatment refuses SoonerCare compensable treatment or diagnostic services and does not plan to pursue the care in the time frames described in OAC 317:35-21-12(a), the case is closed by OKDHS and appropriate notification is computer generated.

(c) In the event a woman is unable to initiate or complete diagnostic services due to a catastrophic illness or injury occurring after certification, SoonerCare will remain open with the approval of a SoonerCare Medical Director or his/her designee.

(d) If it is determined at any time during the certification period that the woman is no longer in need of treatment, the OKDHS worker closes the case and appropriate notification is computer generated.

(e) If it is determined at any time during the certification period that the woman has creditable health insurance coverage, the OKDHS worker closes the case and appropriate notification is computer generated.

(f) If the OKDHS worker later determines that the woman is otherwise eligible for SoonerCare, the worker takes necessary actions to certify her for the appropriate category of SoonerCare coverage.