
POLICY TRANSMITTAL NO. 08-44	DATE: AUGUST 21, 2008
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS AND POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-5-11; 30-5-70; 30-5-70.1; 30-5-70.3; 30-5-72; 30-5-77 through 30-5-77.3; 30-5-78 through 30-5-78.2; 30-5-86; 30-5-740; 30-5-1085 through 30-5-1088; 30-5-1090; 30-5-1091; 30-5-1093 through 30-5-1096; 30-5-1098 through 30-5-1099; and 30-5-1100.

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

Psychiatrist rules are revised to update terminology, clarify correct billing procedures for general physicians performing psychiatric services, and to remove language regarding submission of documentation of training to the Oklahoma Health Care Authority.

Pharmacy rules are revised to comply with the federal mandate requiring the use of the prescriber's National Provider Identification number, remove specific drug names from policy and clean up out-dated terminology.

Residential Behavior Management Services in Foster Care Settings rules are revised to eliminate obsolete provisions and set out required qualifications for individual providers who render Individual Rehabilitative Treatment services for redevelopment therapy in a foster care setting.

Agency rules are revised to update current Indian health rules and add a Section regarding medical care by Indian Health Services (IHS). Rules are also revised to provide additional clarification regarding what is included in the outpatient encounter rate as well as instances when a provider can bill for multiple encounters.

Original signed on 8-19-08

Mary Stalnaker, Director
Family Support Services Division

Sharon Neuwald, Coordinator
Office of Legislative Relations and Policy

WF # 08-S (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.

<u>REMOVE</u>	<u>INSERT</u>
317:30-5-11	317:30-5-11, pages 1-2, revised 7-25-08
317:30-5-70	317:30-5-70, 1 page only, revised 7-25-08
317:30-5-70.1	317:30-5-70.1, 1 page only, revised 7-25-08
317:30-5-70.3	317:30-5-70.3, 1 page only, revised 7-25-08
317:30-5-72	317:30-5-72, pages 1-2, revised 7-25-08
317:30-5-77	317:30-5-77, 1 page only, revised 7-25-08
317:30-5-77.1	317:30-5-77.1, 1 page only, revised 7-25-08
317:30-5-77.2	317:30-5-77.2, pages 1-2, revised 7-25-08
317:30-5-77.3	317:30-5-77.3, pages 1-2, revised 7-25-08
317:30-5-78	317:30-5-78, pages 1-3, revised 7-25-08
317:30-5-78.1	317:30-5-78.1, 1 page only, revised 7-25-08
317:30-5-78.2	317:30-5-78.2, 1 page only, revised 7-25-08
317:30-5-86	317:30-5-86, 1 page only, revised 7-25-08
317:30-5-740	317:30-5-740, pages 1-3, revised 7-25-08
317:30-5-1085	317:30-5-1085, 1 page only, revised 7-25-08
317:30-5-1086	317:30-5-1086, 1 page only, revised 7-25-08

REMOVE

317:30-5-1087
317:30-5-1088
317:30-5-1090
317:30-5-1091
317:30-5-1093
317:30-5-1094
317:30-5-1095
317:30-5-1096
317:30-5-1098
317:30-5-1099
317:30-5-1100

INSERT

317:30-5-1087, 1 page only, revised 7-25-08
317:30-5-1088, 1 page only, revised 7-25-08
317:30-5-1090, 1 page only, revised 7-25-08
317:30-5-1091, 1 page only, revised 7-25-08
317:30-5-1093, 1 page only, revised 7-25-08
317:30-5-1094, 1 page only, revised 7-25-08
317:30-5-1095, 1 page only, revised 7-25-08
317:30-5-1096, 1 page only, revised 7-25-08
317:30-5-1098, pages 1-3. revised 7-25-08
317:30-5-1099, 1 page only, revised 7-25-08
317:30-5-1100, 1 page only, issued 7-25-08

317:30-5-11. Psychiatric services

(a) Payment is made for procedure codes listed in the Psychiatry section of the most recent edition of the American Medical Association Current Procedural Terminology codebook. The codes in this service range are accepted services within the SoonerCare program for children and adults with the following exceptions:

(1) Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.

(2) Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient.

(3) Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers.

(4) Unlisted psychiatric service or procedure.

(b) All services must be medically necessary and appropriate and include a Diagnostic and Statistical Manual (DSM) multi axial diagnosis completed for all five axes from the most recent version of the DSM.

(c) Services in the psychiatry section of the CPT manual must be provided by a board eligible or board certified psychiatrist or a physician, physician assistant, or nurse practitioner with additional training that demonstrates the knowledge to conduct the service performed. For general physicians (M.D. or D.O.), physician assistants, or nurse practitioners, payment is made for the appropriate medical procedure code(s) and not for psychiatric procedure codes.

(d) No services in the psychiatry series of the CPT manual may be provided via telemedicine or other electronic medium, with the exception of "pharmacologic management". Pharmacological management may be performed via telemedicine under the following circumstances:

(1) A healthcare professional with knowledge of the patient must accompany and attend the patient during the performance of the service.

(2) The psychiatrist performing the service or in the case of a group practice or agency, another psychiatrist within that practice or agency must have seen the patient receiving the service during either a psychiatric exam or previous pharmacologic management session or other face-to-face psychiatric service.

(3) The patient must understand the procedure including the

technologic aspects of the process and agree, in writing, to having his/her pharmacological management session via electronic equipment.

(e) The telecommunications equipment must provide clear images of the psychiatrist to the patient. The psychiatrist must have a clear visual field to effectively evaluate the physical condition of the patient, including but not limited to extrapyramidal symptoms, injuries and changes in weight. Audio reception must be sufficient for the patient and physician to clearly hear one another's conversation.

317:30-5-70. Eligible providers

Eligible providers are:

- (1) entities licensed under Title 59 O.S. 353.9 as pharmacies,
or
- (2) entities licensed under another state's law as a pharmacy.

317:30-5-70.1. Pharmacist responsibility

Eligible providers in the SoonerCare program are expected to act in accordance with the rules of professional conduct as promulgated by the Oklahoma Board of Pharmacy (or the state's rules of professional conduct where the pharmacy is licensed) under Title 59 O.S. 353.7(12). A pharmacist may refuse to dispense any prescription which appears to be improperly executed or which, in their professional judgment, is unsafe as presented.

317:30-5-70.3. Prescriber identification numbers

(a) Pharmacies must use the prescriber's National Provider Identification (NPI) number to identify the prescribing provider.

(b) Claims for covered over-the-counter products may be submitted using the prescriber name "OTC" and number referenced on the OHCA's public website.

317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six covered prescriptions per month with a limit of three brand name prescriptions.

(2) Subject to the limitations set forth in OAC 317:30-5-72.1, OAC 317:30-5-77.2, and OAC 317:30-5-77.3, exceptions to the six medically necessary prescriptions per month limit are:

(A) unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded; and

(B) seven additional medically necessary prescriptions which are generic products per month to the six covered under the State Plan are allowed for adults receiving services under the 915(c) Home and Community Based Services Waivers. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization.

(3) Drugs exempt from the prescription limit include: Antineoplastics, anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV), certain prescriptions that require frequent laboratory monitoring, birth control prescriptions, over the counter contraceptives, hemophilia drugs, compensable smoking cessation products, low-phenylalanine formula and amino acid bars for persons with a diagnosis of PKU, certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.), and drugs used for the treatment of tuberculosis.

For purposes of this Section, exclusion from the prescription limit means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month.

(b) **Coverage for children.** Prescription drugs for SoonerCare eligible individuals under 21 years of age are not limited.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are also eligible for the Medicare Part D prescription drug benefit. Coordination of benefits between Medicare Part B and Medicare Part D is the responsibility of the pharmacy provider. The SoonerCare pharmacy benefit does not include any products which are available through either Part B or Part D of Medicare.

(d) Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003. Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. The exclusion will become effective January 1, 2006, or the date Medicare Part D is implemented for dual eligible individuals, whichever is later. This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

317:30-5-77. Brand necessary certification

(a) When a product is available in both a brand and generic form, a prior authorization is required before the branded product may be dispensed. The prescribing provider must certify the brand name drug product is medically necessary for the well being of the patient, otherwise a generic must be substituted for the name brand product.

(1) The certification must be written in the physician's or other prescribing provider's handwriting.

(2) Certification must be written directly on the prescription blank or on a separate sheet which is attached to the original prescription.

(3) A standard phrase indicating the need for a specific brand is required. The OHCA recommends use of the phrase "Brand Necessary".

(4) It is unacceptable to use a printed box on the prescription blank that could be checked by the physician to indicate brand necessary, or to use a hand-written statement that is transferred to a rubber stamp and then stamped onto the prescription blank.

(5) If a physician phones a prescription to the pharmacy and indicates the need for a specific brand, the physician should be informed of the need for a handwritten certification. The pharmacy can either request that the certification document be given to the patient who then delivers it to the pharmacy upon receipt of the prescription, or request the physician send the certification through the mail.

(b) The Brand Necessary Certification applies to CMS Federal Upper Limit and State Maximum Allowable Cost (SMAC) products.

(c) For certain narrow therapeutic index drugs, a prior authorization will not be required. The DUR Board will select and maintain the list of narrow therapeutic index drugs.

317:30-5-77.1. Dispensing Quantity

(a) Prescription quantities are to be limited to a 34 day supply except in the following situations:

(1) The Drug Utilization Review Board has recommended a different day supply or quantity limit based on published medical data, including the manufacturer's package insert, provided the Chief Executive Officer of the OHCA has approved the recommendation;

(2) The product is included on the Maintenance List of medications which are exempt from this limit and may be dispensed up to 100 units;

(3) The manufacturer of the drug recommends a dispensing quantity less than a 34 day supply;

(b) Refills are to be provided only if authorized by the prescriber, allowed by law, and should be in accordance with the best medical and pharmacological practices. A provider may not generate automated refills unless the member has specifically requested such service. Documentation of this request must be available for review by OHCA auditors.

(c) The Drug Utilization Review Board shall develop a Maintenance List of medications which are used in general practice on a continuing basis. These drugs shall be made available through the vendor drug program in quantities up to 100 units when approved by the prescriber. The Drug Utilization Review Board shall review the Maintenance List at least annually. The Maintenance List shall be approved by the Chief Executive Officer of OHCA. When approved by the prescriber, all maintenance medications must be filled at the maximum quantity allowed after a sufficient stabilization period when dispensed to SoonerCare members who do not reside in a long term care facility. For members residing in a long term care facility, chronic medications, including all products on the Maintenance List, must be dispensed in quantities of not less than a 28 day supply.

(d) For products covered by the Oklahoma Vendor Drug Program the metric quantity shown on the claim form must be in agreement with the descriptive unit of measure applicable to the specific NDC. Only numeric characters should be entered. Designations, such as the form of drug, i.e., Tabs, Caps, Suppositories, etc., must not be used. Products should be billed in a manner consistent with quantity measurements.

317:30-5-77.2. Prior authorization

(a) **Definition.** The term prior authorization in pharmacy means an approval for payment by OHCA to the pharmacy before a prescription is dispensed by the pharmacy. An updated list of all products requiring prior authorization is available at the agency's website.

(b) **Process.** Because of the required interaction between a prescribing provider (such as a physician) and a pharmacist to receive a prior authorization, OHCA allows a pharmacist up to 30 calendar days from the point of sale notification to provide the data necessary for OHCA to make a decision regarding prior authorization. Should a pharmacist fill a prescription prior to the actual authorization he/she takes a business risk that payment for filling the prescription will be denied. In the case that information regarding the prior authorization is not provided within the 30 days, claims will be denied.

(c) **Documentation.** Prior Authorization petitions with clinical exceptions must be mailed or faxed to the Medication Authorization Unit of OHCA's contracted prior authorization processor. Other authorization petitions, claims processing questions and questions pertaining to DUR alerts must be addressed by contacting the Pharmacy help desk. Authorization petitions with complete information are reviewed and a response returned to the dispensing pharmacy within 24 hours. Petitions and other claim forms are available on the OHCA public website.

(d) **Emergencies.** In an emergency situation the Health Care Authority will authorize a 72 hour supply of medications to a member. The authorization for a 72 hour emergency supply of medications does not count against the SoonerCare limit described in OAC 317:30-5-72(a)(1).

(e) **Utilization and scope.** There are three reasons for the use of prior authorization: utilization controls, scope controls and product based controls. Product based prior authorization is covered in OAC 317:30-5-77.3. The Drug Utilization Review Board recommends the approved clinical criteria and any restrictions or limitations.

(1) **Utilization controls.** Prior authorizations that fall under this category generally apply to the quantity of medication or duration of therapy approved.

(2) **Scope controls.** Scope controls are used to ensure a drug is used for an approved indication and is clinically appropriate, medically necessary and cost effective.

(A) Medications which have been approved by the FDA for multiple indications may be subject to a scope-based prior authorization when at least one of the approved indications

places that drug into a therapeutic category or treatment class for which a prior authorization is required. Prior authorizations for these drugs may be structured as step therapy or a tiered approach as recommended by the Drug Utilization Review Board and approved by the OHCA Board of Directors.

(B) Prior authorization may be required to assure compliance with FDA approved and/or medically accepted indications, dosage, duration of therapy, quantity, or other appropriate use criteria including pharmacoeconomic consideration.

(C) Prior authorization may be required for certain non-standard dosage forms of medications when the drug is available in standard dosage forms.

317:30-5-77.3. Product

(a) The Oklahoma Health Care Authority utilizes a prior authorization system subject to their authority under 42 U.S.C. 396r-8 and 63 O.S. 5030.3(B). The prior authorization program is not a drug formulary which is separately authorized in 42 U.S.C. 396r-8. Drugs are placed into two or more tiers based on similarities in clinical efficacy, side-effect profile and cost-effectiveness after recommendation by the Drug Utilization Review Board and OHCA Board approval. Drugs placed in tier number one require no prior authorization. Drugs placed in any tier other than tier number one require prior authorization.

(1) Three exceptions exist to the requirement of prior authorization:

- (A) inadequate response to one or more tier one products,
- (B) a clinical exception for a certain product in the particular therapeutic category, or
- (C) the manufacturer or labeler of a product may opt to participate in the state supplemental drug rebate program to move a product from a higher tier to a lower tier which will remove or reduce the prior authorization requirement for that product.

(i) After a drug or drug category has been added to the Prior Authorization program, OHCA or its contractor may establish a cost-effective benchmark value for each therapeutic category or individual drug. The benchmark value may be calculated based on an average cost, an average cost per day, a weighted average cost per day or any other generally accepted economic formula. A single formula for all drugs or drug categories is not required.

Supplemental rebate offers from manufacturers which are greater than the minimum required supplemental rebate will be accepted and may establish a new benchmark rebate value for the category.

(ii) Manufacturers of products assigned to tiers number two and higher may choose to pay a supplemental rebate to the state in order to avoid a prior authorization on their product or products assigned to the higher tier.

(iii) Supplemental rebate agreements shall be in effect for one year and may be terminated at the option of either party with a 60 day notice. Supplemental rebate agreements are subject to the approval of CMS. Termination of a Supplemental Rebate agreement will result in the specific product reverting to the previously assigned higher tier in the PBPA program.

(iv) The supplemental unit rebate amount for a tier two or

higher product will be calculated by subtracting the federal rebate amount per unit from the benchmark rebate amount per unit.

(v) Supplemental rebates will be invoiced concurrent with the federal rebates and are subject to the same terms with respect to payment due dates, interest, and penalties for non-payment as specified at 42 U.S.C. Section 1396r-8. All terms and conditions not specifically listed in federal or state law shall be included in the supplemental rebate agreement as approved by CMS.

(vi) Drugs or drug categories which are not part of the Product Based Prior Authorization program as outlined in 63 O.S. Section 5030.5 may be eligible for supplemental rebate participation. The OHCA Drug Utilization Review Board shall determine supplemental rebate eligibility for drugs or drug categories after considering clinical efficacy, side effect profile, cost-effectiveness and other applicable criteria.

(2) All clinical exceptions are recommended by the Drug Utilization Review Board and demonstrated by documentation sent by the prescribing physician and pharmacist.

(b) Additional therapeutic categories of drugs will be subject to subsection (a) of this Section if recommended by the Drug Utilization Review Board, considered by the Medical Advisory Committee and approved by the OHCA Board.

317:30-5-78. Reimbursement

(a) Reimbursement. Reimbursement for pharmacy claims is based on the sum of an estimate of the ingredient cost plus a dispensing fee.

(b) Ingredient Cost. Ingredient cost is estimated by one of the following methods:

(1) **Maximum Allowable Cost.**

(A) The State Maximum Allowable Cost (MAC) is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The State MAC will be calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific product's MAC price by providing invoices that reflect a net cost higher than the calculated State MAC price and by certifying that there is not another product available to them which is generically equivalent to the higher priced product.

(B) The Federal Upper Limit (FUL) is established by CMS in accordance with applicable federal laws and regulations.

(2) **The Estimated Acquisition Cost.** The Estimated Acquisition Cost (EAC) means the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler. EAC is typically based on a benchmark published price plus or minus a percentage.

The current benchmark price is the Average Wholesale Price (AWP) as provided by the OHCA's pricing resource. EAC is calculated as AWP minus 12%.

(c) Maximum allowable dispensing fee. The maximum allowable dispensing fee for prescribed medication is established by review of surveys. A recommendation is made by the Rates and Standards Committee and presented to the Oklahoma Health Care Authority Board for their approval. There may be more than one level or type of dispensing fee if approved by the OHCA Board and CMS. A contracted pharmacy agrees to participate in any survey conducted by the OHCA with regard to dispensing fees. The pharmacy shall furnish all necessary information to determine the cost of dispensing drug products. Failure to participate may result in administrative sanctions by the OHCA which may include but are not limited to a reduction in the dispensing fee.

(d) Payment for prescription claims. Payment for prescription claims will be:

(1) the lower of estimated acquisition cost, Federal Upper Limit (FUL), or State Maximum Allowable Cost (SMAC) plus a dispensing fee, or

(2) usual and customary charge to the general public, whichever is lower. The pharmacy is responsible to determine its usual and customary charge to the general public. The OHCA may conduct periodic reviews within its audit guidelines to verify the pharmacy's usual and customary charge to the general public and the pharmacy agrees to make available to the OHCA's reviewers prescription and pricing records deemed necessary by the reviewers. The OHCA defines general public as the patient group accounting for the largest number of non-SoonerCare prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through other third-party payers. If a pharmacy offers discount prices to a portion of its customers (i.e. -10% discount to senior citizens), these lower prices would be excluded from the usual and customary calculations unless the patients receiving the favorable prices represent more than 50% of the pharmacy's prescription volume. The usual and customary charge will be a single price which includes both the product price and the dispensing fee. For routine usual and customary reviews, the pharmacy may provide prescription records for non-SoonerCare customers in a manner which does not identify the customer by name so long as the customer's identity may be determined later if a subsequent audit is initiated. The OHCA will provide the pharmacy notice of its intent to conduct a review of usual and customary charges at least ten days in advance of its planned date of review.

(e) Payment of Claims. In order for an eligible provider to be paid for filling a prescription drug, the pharmacy must complete all of the following:

- (1) have an existing provider agreement with OHCA,
- (2) submit the claim in a format acceptable to OHCA,
- (3) have a prior authorization before filling the prescription, if a prior authorization is necessary,
- (4) have a proper brand name certification for the drug, if necessary, and
- (5) include the usual and customary charges to the general public as well as the estimated acquisition cost and dispensing fee.

(f) Claims. Prescription reimbursement may be made only for individuals who are eligible for coverage at the time a prescription is filled. Member eligibility information may be accessed by swiping a SoonerCare identification card through a commercial card swipe machine which is connected to the eligibility database or via the Point of Sale (POS) system when a prescription

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

OAC 317:30-5-78 (p3)

claim is submitted for payment. Persons who do not contract with commercial vendors can use the Member Eligibility Verification System (EVS) at no additional cost.

317:30-5-78.1. Special billing procedures

(a) **Antihemophiliac Factor (AHF) Products.** AHF products are sold by the amount of drug (International Units of AHF) in the container. For their products, regardless of the container size, the package size is always "1". Therefore, pricing assumes that the "package size" actually dispensed is the actual number of units dispensed. Examples: If 250 AHF units are dispensed and multiplied by a unit cost of \$.25, the allowable cost would be \$62.50. Metric Quantity is shown as 250; if 500 AHF units are dispensed and multiplied by a unit cost of \$.25, the allowable would be \$125.00. Metric Quantity is shown as 500.

(b) **Compound and intravenous drugs.** Prescriptions claims for compound and Intravenous (IV) drugs are billed and reimbursed using the NDC number and quantity for each compensable ingredient in the compound or IV, up to 25 ingredients. Ingredients without an NDC number are not compensable. A dispensing fee as described in OAC 317:30-5-78(c) is added to the total ingredient cost.

(c) **Co-Payment.** Pharmacies must pursue all third party resources before filing a claim with OHCA as set out in 42 CFR 433.139.

(d) **Over-the-counter drugs.** Payment for covered over-the-counter medication is made according to the reimbursement methodology in OAC 317:30-5-78(d).

(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the SoonerCare allowable for comparable services. The appropriate Durable Medical Equipment Regional Carrier (DMERC) must be billed prior to billing OHCA for all Medicare compensable drugs.

Part B crossover claims cannot be submitted through the pharmacy point of sale system and must be submitted using the CMS 1500 form or electronic equivalent.

(f) **Claims for prescriptions which are not picked up.** A prescription for a member which has been submitted to and approved for payment by OHCA which has not been received by the member within 15 days of the date of service must be reversed. An electronic reversal will cause a refund to be generated to the agency. Claims may also be reversed using a manual process if electronic reversal is not possible. For the purpose of this Section, the date of service means the date the prescription was filled.

317:30-5-78.2. Falsification of claims

No pharmacist shall knowingly present or cause to be presented a false or fraudulent claim for payment. No pharmacist shall knowingly make, use or caused to be made or used, a false record or statement to get a false or fraudulent claim paid or approved. The term knowingly shall mean that a person, with respect to information has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information or acts in reckless disregard of the truth or falsity of the information. Violation of this section may lead to actions from education of the provider, to recoupment of payment to criminal penalties as prescribed in OAC 317:30-3-18.

317:30-5-86. Drug Utilization Review Program

(a) OHCA is authorized by federal statute to conduct prospective and retrospective review of pharmacy claims to insure that prescriptions are:

- (1) appropriate,
- (2) medically necessary, and
- (3) not likely to result in adverse medical results.

(b) OHCA is authorized to use this program to educate physicians, other prescribers, pharmacists, and patients and also to conserve program funds and personal expenditures and prevent fraud, abuse and misuse of prescriptions.

(c) OHCA utilizes a DUR Board managed by an outside contractor to review and analyze clinical and economic data available. The DUR Board reviews and makes recommendations based on predetermined standards submitted to them by the OHCA contractor(s) and, in concert with the retrospective review of claims data, makes recommendations for educational interventions, prospective DUR and the prior authorization process.

**MEDICAL PROVIDERS-FEE FOR SERVICE
RESIDENTIAL BEHAVIOR MANAGEMENT
SERVICES IN FOSTER CARE SETTINGS**

OAC 317:30-5-740 p(1)

317:30-5-740. Eligible providers

(a) Eligible Residential Behavior Management Service (RBMS) agencies must:

- (1) have a current certification from the Oklahoma Department of Human Services (OKDHS) as a child placing agency, and
- (2) have a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, and
- (3) have a contract with the Oklahoma Health Care Authority.

(b) Effective July 1, 2002, an eligible RBMS must:

- (1) have a current certification from the Oklahoma Department of Human Services (OKDHS) as a child placing agency, and
- (2) have a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, and
- (3) have a contract with the Oklahoma Health Care Authority, and
- (4) have current accreditation status appropriate to provide behavioral management services in a foster care setting from:
 - (A) Joint Commission on Accreditation of Health Care Organization (JCAHO), or
 - (B) the Rehabilitation Accreditation Commission (CARF), or
 - (C) the Council on Accreditation (COA), or
 - (D) the American Osteopathic Association (AOA).

(c) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services of their providers for behavior management therapies in a foster care setting, providers must have the following qualifications:

- (1) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, alcohol and drug counselor, or under Board approved supervision to be licensed in one of the above stated areas; or
- (2) be licensed as an advanced practice nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided AND
- (3) demonstrate a general professional or educational background in the following areas:
 - (A) case management, assessment and treatment planning;
 - (B) treatment of victims of physical, emotional, and sexual abuse;
 - (C) treatment of children with attachment disorders;
 - (D) treatment of children with hyperactivity or attention deficit disorders;

**MEDICAL PROVIDERS-FEE FOR SERVICE
RESIDENTIAL BEHAVIOR MANAGEMENT
SERVICES IN FOSTER CARE SETTINGS**

OAC 317:30-5-740 p(2)

- (E) treatment methodologies for emotionally disturbed children and youth;
- (F) normal childhood development and the effect of abuse and/or neglect on childhood development;
- (G) treatment of children and families with substance abuse and chemical dependency disorders;
- (H) anger management;
- (I) crisis intervention; and
- (J) trauma informed methodology.

(d) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for Group Rehabilitative Treatment Services in a foster care setting facilitated by their staff, providers must have the following qualifications:

(1) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, alcohol and drug counselor, or behavioral practitioner, or under Board approved supervision to be licensed in one of the above stated areas; or

(2) be licensed as an advanced practice nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided; or

(3) have a baccalaureate degree in a behavioral health field, a minimum of one year of experience in providing direct care and/or treatment to children and/or families, and have access to weekly consultation with a licensed mental health professional.

(e) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for Individual Rehabilitative Treatment Services for redevelopment therapy in a foster care setting facilitated by their staff, providers must have the following qualifications:

(1) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, alcohol and drug counselor, or behavioral practitioner, or under Board approved supervision to be licensed in one of the above stated areas; or

(2) be licensed as an advanced practice nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided; or

(3) have a baccalaureate degree in a behavioral health field, a minimum of one year of experience in providing direct care

**MEDICAL PROVIDERS-FEE FOR SERVICE
RESIDENTIAL BEHAVIOR MANAGEMENT
SERVICES IN FOSTER CARE SETTINGS**

OAC 317:30-5-740 p(3)

and/or treatment to children and/or families, and have access to weekly consultation with a licensed mental health professional;
or

(4) be classified by the RBMS agency as a Treatment Parent Specialist under the supervision of a licensed, or under-supervision for licensure, behavioral health professional of the RBMS.

(A) The Treatment Parent Specialist must meet the following criteria:

(i) have a high school diploma or equivalent;

(ii) be employed by the RBMS as a foster parent complete with OSBI and OKDHS background screening;

(iii) completion of therapeutic foster parent training outlined in 317:30-5-740.1(a);

(iv) have a minimum of twice monthly face to face supervision with the licensed, or under-supervision for licensure, professional;

(v) have weekly contact with the RBMS professional staff;
and

(vi) complete required annual trainings.

**MEDICAL PROVIDERS-FEE FOR SERVICE
INDIAN HEALTH SERVICES, TRIBAL PROGRAMS,
AND URBAN INDIAN CLINICS (I/T/US)**

OAC 317:30-5-1085

317:30-5-1085. General provisions

(a) Indian Health Services (IHS) provide health care to Certificate of Degree of Indian Blood (CDIB) eligible American Indian and Alaska Natives (AI/AN). The IHS is a division of the Department of Health and Human Services that administers a system of hospitals and Indian health outpatient services. Urban Indian Clinics are considered facilities of the IHS. Under the Indian Self-Determination Act, Public Law 93-638, as amended, Tribes may also provide health care to CDIB eligible AI/ANs.

(b) The rules at OAC 317:30-3 apply to IHS, Tribal, and Urban Indian facilities. Additionally, unless otherwise stated, all other SoonerCare rules apply to IHS, Tribal, and Urban Indian facilities.

**MEDICAL PROVIDERS-FEE FOR SERVICE
INDIAN HEALTH SERVICES, TRIBAL PROGRAMS,
AND URBAN INDIAN CLINICS (I/T/US)**

OAC 317:30-5-1086

317:30-5-1086. Eligible I/T/U providers

Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us) are considered eligible for participation in the SoonerCare Program. To receive SoonerCare reimbursement, an I/T/U must have a current contract on file with the Oklahoma Health Care Authority (OHCA). OHCA recognizes that I/T/Us are the payer of last resort, and are not considered creditable health insurance.

317:30-5-1087. Terms and definitions

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

(1) **"American Indian/Alaska Native (AI/AN)"** means an individual of Native American descent who has or is eligible for a Certificate of Degree of Indian Blood (CDIB) card.

(2) **"Behavioral Health services"** means professional medical services for the treatment of a mental health and/or addiction disorder(s).

(3) **"CFR"** means the Code of Federal Regulations.

(4) **"CMS"** means the Centers for Medicare and Medicaid Services.

(5) **"Encounter"** means a face to face contact between a health care professional and a CDIB card eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a 24-hour period ending at midnight, as documented in the patient's record.

(6) **"Licensed Behavioral Health Professional (LBHP)"** means a licensed psychologist, licensed clinical social worker (LSW-C), licensed marital and family therapist (LMFT), licensed professional counselor (LPC), licensed behavioral practitioner (LBP) or licensed alcohol and drug counselor (LADC).

(7) **"OHCA"** means the Oklahoma Health Care Authority.

(8) **"OMB rate"** means the Medicaid reimbursement rate negotiated between CMS and IHS. Inpatient and outpatient Medicaid reimbursement rates for I/T/Us are published annually in the Federal Register or Federal Register Notices. The outpatient rate is also known as the I/T/U encounter rate. The encounter rate is available only to I/T/U facilities that appear on the IHS maintained listing of IHS-operated and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list.

(9) **"Physician"** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery or who is a licensed physician employed by the Federal Government in an IHS facility or who provides services in a 638 Tribal Facility.

(10) **"State Administering Agency (SAA)"** is the Oklahoma Health Care Authority.

(11) **"638 Tribal Facility"** is a facility that is operated by a tribe or tribal organization and funded by Title I or Title III of the Indian Self Determination and Education Assistance Act (Public Law 93-638).

317:30-5-1088. I/T/U provider participation requirements

(a) I/T/Us must either directly employ or contract the services of legally credentialed professional staff that are authorized within their scope of practice under state law to provide the services for which claims are submitted to SoonerCare; or I/T/U Physicians may meet all requirements for employment by the Federal Government as a physician and be employed by the Federal Government in an IHS facility or affiliated with a 638 Tribal Facility.

(b) The facility is required to report professional staff contracted or employed by the I/T/U to the OHCA. Participating I/T/Us are required to submit a list of names of all practitioners working within the facility and a list of all individual OHCA provider and National Provider Identifier (NPI) numbers. The reimbursement for the services rendered at or on behalf of the I/T/U will be made to the facility.

(c) The following professional staff are recognized by OHCA:

- (1) Physicians;
- (2) Licensed Physician Assistants;
- (3) Dentists;
- (4) Pharmacists;
- (5) Advanced Practice Nurses (APNs) which include:
 - (A) Advanced Registered Nurse Practitioners (ARNPs);
 - (B) Certified Nurse Midwives (CNMs);
 - (C) Certified Registered Nurse Anesthetists (CRNAs); and
 - (D) Clinical Nurse Specialists (CNSs);
- (6) Registered nurses under the supervision of a licensed physician; and
- (7) Practitioners who are actively and regularly receiving board approved supervision, or those receiving extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet fully licensed for the services that are within the practitioner's scope of practice.
This includes but is not limited to:
 - (A) licensed clinical social workers (LSW-C);
 - (B) marital and family therapists (LMFT);
 - (C) licensed professional counselors (LPC);
 - (D) licensed behavioral practitioners (LBP); and
 - (E) licensed alcohol and drug counselors (LADC).

317:30-5-1090. Provision of other health services outside of the I/T/U encounter

(a) An I/T/U outpatient facility may provide other items and services which are not part of an encounter. If covered, these services are separately billable to the SoonerCare program. Coverage of services will be based upon medical necessity and the scope of coverage under the SoonerCare program and subject to any limitations, restrictions or prior authorization requirements.

(b) Medically necessary SoonerCare covered services that are not included in the I/T/U outpatient encounter rate may be billed outside the encounter rate within the scope of the SoonerCare fee-for-service rate. Examples of these services include but are not limited to:

- (1) pharmaceuticals/drugs;
- (2) durable medical equipment;
- (3) glasses;
- (4) ambulance;
- (5) home health;
- (6) inpatient practitioner services;
- (7) non-emergency transportation [refer to OAC 317:35-3-2];
- (8) behavioral health case management [refer to OAC 317:30-5-585 through 317:30-5-589 and OAC 317:30-5-595 through 317:30-5-599];
- (9) psychosocial rehabilitative services [refer to OAC 317:30-5-240 through 317:30-5-248]; and
- (10) psychiatric residential treatment facility services [refer to OAC 317:30-5-96.3].

(c) If the I/T/U facility chooses to provide other SoonerCare State Plan covered health services which are not included in the I/T/U encounter definition, those service providers must be contracted with OHCA and bill for those services under their assigned provider number consistent with program coverage limitations and billing procedures described by the OHCA.

317:30-5-1091. Definition of I/T/U services

(a) As described in Title 42 of the Code of Federal Regulations (CFR) 136.11(a), the I/T/U services may include hospital and medical care, dental care, public health nursing and preventive care (including immunizations), and health examination of special groups such as school children.

(b) Further, Title 42 CFR 136.11(c) allows that the scope and availability of I/T/U services will depend upon the resources of the facility.

(c) I/T/U services may be covered when furnished to a patient at the clinic or other location, including a mobile clinic, or the patient's place of residence.

(d) I/T/U outpatient encounters include but are not limited to:

(1) Physicians' services and supplies incidental to a physician's services;

(2) Within limitations as to the specific services furnished, a doctor of dentistry or oral surgery, a doctor of optometry, or a doctor of podiatry [Refer to Section 1861(r) of the Act for specific limitations];

(3) The services of a resident as defined in OAC 317:25-7-5(4) who meets the requirements for payment under SoonerCare and the supplies incidental to a resident's services;

(4) Services of advanced practice nurses (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;

(5) Services and supplies incidental to the services of APNs and PAs (including services furnished by certified nurse midwives);

(6) Visiting nurse services to the homebound;

(7) Behavioral health professional services and services and supplies incidental to the services of LBHPs; and

(8) Dental services.

317:30-5-1093. I/T/U visiting nurses services

(a) Visiting nurse services may be covered if:

(1) The services are rendered to a homebound individual;

(2) The services are furnished by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by, or receives compensation for the services from the I/T/U; and

(3) The services are furnished under a written plan of treatment that is:

(A) established and reviewed at least every 60 days by a supervising physician of the I/T/U or established by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner and reviewed at least every 60 days by a supervising physician; and

(B) signed by the nurse practitioner, physician assistant, nurse midwife, specialized nurse practitioner, or the supervising physician of the clinic.

(b) The nursing care covered in this Section includes:

(1) Services that must be performed by a registered nurse, licensed practical nurse, or licensed vocational nurse if the safety of the patient is to be assured and the medically desired results achieved; and

(2) Personal care services, to the extent covered under Medicare as home health services. These services include helping the patient to bathe, to get in and out of bed, to exercise and to take medications.

(c) This benefit does not cover household and housekeeping services or other services that would constitute custodial care.

(d) For purposes of this Section, homebound means an individual who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. The individual may be considered homebound if he or she leaves the place of residence infrequently. For this purpose, place of residence does not include a hospital or long term care facility.

**MEDICAL PROVIDERS-FEE FOR SERVICE
INDIAN HEALTH SERVICES, TRIBAL PROGRAMS,
AND URBAN INDIAN CLINICS (I/T/US)**

OAC 317:30-5-1094

317:30-5-1094. Behavioral health services provided at I/T/Us

(a) Behavioral health services that are primary, preventive, and therapeutic and would be covered if provided in another setting may be provided by I/T/U providers. Services provided by an I/T/U (refer to OAC 317:30-5-241 for a description of services) must meet the same requirements as services provided by another provider. Services include:

- (1) Mental Health Assessment/Evaluation Testing;
- (2) Alcohol and/or Substance Abuse Services Assessment and Treatment Plan Development;
- (3) Crisis Intervention Services;
- (4) Medication Training and Support;
- (5) Individual/interactive Psychotherapy;
- (6) Group Psychotherapy; and
- (7) Family Psychotherapy.

(b) Behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified mental health and/or substance abuse disorder(s). A minimum of a 45 to 50 minute standard clinical session must be completed by an I/T/U in order to bill an encounter for the session.

(c) In order to support access to mental health services, these services may be provided in settings outside of the I/T/U. Offsite services must take place in a confidential setting.

(d) The outpatient behavioral health services' provider enrollment and reimbursement process in no way changes the OHCA's policy with regard to reimbursement of practitioners. Licensed clinical social workers (LSW-C), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), and licensed alcohol and drug counselors (LADC) are not eligible for direct reimbursement as practitioners.

Their services are compensable only when billed by their employers and when provided in those clinical settings in which they are currently approved to render services.

(e) For the provision of behavioral health related case management services, I/T/U providers must meet the requirements found at OAC 317:30-5-585 through 317:30-5-589 and OAC 317:30-5-595 through 317:30-5-599, and be contracted as such. The provision of these services is considered to be outside of the I/T/U encounter.

(f) For the provision of psychosocial rehabilitation services, I/T/U facilities meet the requirements found at OAC 317:30-5-240 through 317:30-5-248, and must contract as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter.

**MEDICAL PROVIDERS-FEE FOR SERVICE
INDIAN HEALTH SERVICES, TRIBAL PROGRAMS,
AND URBAN INDIAN CLINICS (I/T/US)**

OAC 317:30-5-1095

317:30-5-1095. I/T/U services not compensable under outpatient encounters

(a) I/T/U services that are not compensable under outpatient encounters include:

- (1) group or mass information programs, health education classes, or group education activities, including media productions and publications;
- (2) vaccines covered by the Vaccines for Children program [refer to OAC 317:30-5-14(a)(1)];
- (3) group or sports physicals and medical reports;
- (4) drug samples or other prescription drugs provided to the clinic free of charge;
- (5) administrative medical examinations and report services; and
- (6) gauze, band-aids, or other disposable products used during an office visit.

(b) Exclusions from the definition of I/T/U encounters include but are not limited to:

- (1) Durable medical equipment or medical supplies not generally provided during the course of a clinic visit such as diabetic supplies;
- (2) Pharmaceutical or biologicals not generally provided during the clinic visit. For example, sample medications are part of the encounter but dispensing a prescription is billed separately under the fee-for-service pharmacy program;
- (3) Other services that are not defined in this rule or the State Plan under Title XIX or Title XXI of the Social Security Act.
- (4) Eyeglasses (refer to OAC 317:30-5-450);
- (5) Emergency ambulance transportation (refer to OAC 317:30-5-335);
- (6) Non-emergency transportation;
- (7) 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;
- (8) Behavioral health rehabilitative services [see OAC 317:30-5-241];
- (9) hearing aids; and
- (10) Behavioral health case management service [refer to OAC 317:30-585 through 317:30-589 and OAC 317:30-5-595 through 317:30-5-599].

**MEDICAL PROVIDERS-FEE FOR SERVICE
INDIAN HEALTH SERVICES, TRIBAL PROGRAMS,
AND URBAN INDIAN CLINICS (I/T/US)**

OAC 317:30-5-1096

317:30-5-1096. I/T/U off-site services

I/T/U covered services provided off-site or outside of the I/T/U setting are compensable when billed by the I/T/U. The I/T/U must have a written contract with the physician and other practitioners that specifies that the I/T/U will bill SoonerCare for services provided off-site and how such providers will be compensated.

**MEDICAL PROVIDERS-FEE FOR SERVICE
INDIAN HEALTH SERVICES, TRIBAL PROGRAMS,
AND URBAN INDIAN CLINICS (I/T/US)**

OAC 317:30-5-1098 (p1)

317:30-5-1098. I/T/U outpatient encounters

(a) I/T/U outpatient encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by the OHCA. These services include health services included in the State Plan under Title XIX or Title XXI of the Social Security Act.

(b) The following words and terms have the following meaning unless the context clearly indicates otherwise:

(1) An I/T/U outpatient encounter is a face-to-face contact between a health care professional and a CDIB card eligible SoonerCare member for the provision of Title XIX and Title XXI covered outpatient services in an I/T/U facility within a 24-hour period ending at midnight, as documented in the patient's medical record.

(2) An I/T/U encounter means outpatient services that may be covered when furnished to a patient by employees of the I/T/U facility at the I/T/U facility or other location, including the patient's place of residence.

(c) The following services may be considered reimbursable encounters subject to the limitations of the Oklahoma State Plan and include any related medical supplies provided during the course of the encounter:

(1) Medical;

(2) Diagnostic;

(3) Behavioral Health services [refer to OAC 317:30-5-1094];

(4) Dental, Medical and Mental Health Screenings;

(5) Vision;

(6) Physical Therapy;

(7) Occupational Therapy;

(8) Podiatry;

(9) Speech;

(10) Hearing;

(11) Visiting Nurse Services;

(12) Other Title XIX or XXI services as allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules;

(13) Drugs or medication treatments provided during a clinic visit are part of the encounter rate. For example, a member has come into the clinic with high blood pressure and is treated at the clinic with a hypertensive drug or drug sample. Drug samples are included in the encounter rate. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;

(14) Encounters with a registered professional nurse or a

licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members; and

(15) I/T/U Multiple Outpatient Encounters.

(A) OHCA will cover one medically necessary outpatient medical encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit with a different diagnosis. Then, a second encounter is allowed.

(B) OHCA will cover one dental encounter per member per day regardless of how many procedures are done or how many providers are seen unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(C) OHCA will cover one behavioral health professional outpatient encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(D) Each service must have distinctly different diagnoses in order to meet the criteria for multiple I/T/U outpatient encounters. For example, a medical visit and a dental visit on the same day are considered different services with distinctly different diagnoses.

(E) Similar services, even when provided by two different I/T/U health care practitioners, are not considered multiple encounters. Situations that would not be considered multiple encounters provided on the same date of service include, but are not limited to:

(i) A well child check and an immunization;

(ii) A preventive dental screen and fluoride varnish application in a single setting;

(iii) A medical encounter with a mental health or addiction diagnosis on the same day as a mental health or addiction encounter;

(iv) A mental health and addiction encounter with similar diagnosis;

(v) Any time a member receives only a partial service with one provider and partial service from another provider. This would be considered a single encounter.

(d) More than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. This does not imply that if a member

**MEDICAL PROVIDERS-FEE FOR SERVICE
INDIAN HEALTH SERVICES, TRIBAL PROGRAMS,
AND URBAN INDIAN CLINICS (I/T/US)**

OAC 317:30-5-1098 (p3)

is seen at a single office visit with multiple problems that multiple encounters can be billed. For example, a member comes to the clinic in the morning for an immunization, and in the afternoon, the member falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two encounters. However, a member who comes to the I/T/U facility for a prenatal visit in the morning and delivers in the afternoon would not be considered a distinctly different diagnosis and can only be billed as a single encounter.

(e) The following services may be considered as separate or multiple encounters when two or more services are provided on the same date of service with distinctly different diagnoses:

- (1) Medical Services;
- (2) Dental Services;
- (3) Mental Health and addiction services with similar diagnoses can only be billed as one encounter. In addition, if the member is also seen for a medical office visit with a mental health or addiction diagnosis, then it is considered a single encounter;
- (4) Physical or occupational therapy (PT/OT). If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter;
- (5) Administration of immunizations. If no other medical office visit occurs on the same date of services; and
- (6) Tobacco cessation limited to state plan services. If no other medical or addiction encounter occurs on the same date of service.

(f) I/T/U outpatient encounters for CDIB eligible SoonerCare members whether medical, dental, or behavioral health, are not subject to prior authorization. Other State Plan covered services that the I/T/U facility chooses to provide but which are not part of the I/T/U encounter are subject to all applicable SoonerCare regulations which govern the provision and coverage for that service.

317:30-5-1099. I/T/U service limitations

Service limitations governing the provision of all Oklahoma SoonerCare services will apply pursuant to Chapter 30 of the OHCA rules. In addition, the following limitations and requirements apply to services provided by I/T/U facilities:

- (1) **Multiple encounters.** An I/T/U facility may bill for more than one encounter per 24 hour period under certain conditions.
- (2) **Behavioral Health services.** Behavioral Health Services are limited to those services furnished to members at or on behalf of the I/T/U facility.
- (3) **Laboratory procedures.** Laboratory procedures performed by an I/T/U outpatient facility (not an independently certified enrolled laboratory) are considered part of the health care practitioner's service and are included in the I/T/U encounter.

**MEDICAL PROVIDERS-FEE FOR SERVICE
INDIAN HEALTH SERVICES, TRIBAL PROGRAMS,
AND URBAN INDIAN CLINICS (I/T/US)**

OAC 317:30-5-1100

317:30-5-1100. Inpatient care provided by IHS facilities

The Inpatient hospital per diem rate for inpatient medical care provided by IHS facilities is published annually in the Federal Register or Federal Register Notices. In order to receive the inpatient hospital per diem rate, the IHS or Tribal 638 facility must:

- (1) be contracted as a provider with the Oklahoma Health Care Authority; and
- (2) appear on the IHS maintained listing of IHS-operated and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list.