
POLICY TRANSMITTAL NO. 07-13	DATE: MARCH 28, 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 317:30-5-2, 30-5-695, 30-5-696, 30-5-696.1, 30-5-698,
30-5-1076, 45-7-1, 45-7-2, 45-7-8, 45-11-10, and 45-11-11.

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

Dental rules are revised to: (1) to add a limited dental benefits for pregnant women; (2) expand coverage for dental sealants for children up to age 18 to guard against tooth decay; (3) eliminate the age restriction on stainless steel crowns for children with 70 percent or more of root structure; (4) to clarify language on Smoking Cessation in dental policy to agree with other sections of policy by adding dentists as providers of this benefit; (5) separate rules regarding conscious sedation into their own Section; and (6) clarify general language.

Nutrition Services rules are revised to increase the maximum hours of medically necessary nutritional counseling by a licensed registered dietician to six hours per year.

O-EPIC rules are revised to update and clarify the covered benefits, limits, and applicable co-payments for the Individual Plan benefit package. Additional revisions clarify employer eligibility procedures for the O-EPIC Premium Assistance (PA) program; in addition to the OES-3 form, employers will be able to provide documentation regarding terminated or part time employees to determine the number of company employees.

Original signed on 3-22-07

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WF # 07-E (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>
317:30-5-2	317:30-5-2, pages 1-12, revised 2-1-07
317:30-5-695	317:30-5-695, 1 page only, revised 2-1-07
317:30-5-696	317:30-5-696, pages 1-9, revised 2-1-07
317:30-5-696.1	317:30-5-696.1, 1 page only, issued 2-1-07
317:30-5-698	317:30-5-698, pages 1-5, revised 2-1-07
317:30-5-1076	317:30-5-1076, 1 page only, revised 2-1-07
317:45-7-1	317:45-7-1, 1 page only, revised 2-1-07
317:45-7-2	317:45-7-2, 1 page only, revised 2-1-07
317:45-7-8	317:45-7-8, 1 page only, revised 2-1-07
317:45-11-10	317:45-11-10, pages 1-4, revised 2-1-07
317:45-11-11	317:45-11-11, pages 1-2, revised 2-1-07

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

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

(1) Coverage includes the following medically necessary services:

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

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

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

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

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

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

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

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month denied by Medicare for a Medicare/SoonerCare patient, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

(I) Diagnostic x-ray and laboratory services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) Seeing members without supervision;

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

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

(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

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

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

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

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

(II) Advising the member to quit;

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

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

(V) Arranging for follow-up.

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

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, nurse practitioners, nurse midwives, dentists, and Oklahoma State Health Department and FQHC nursing staff. It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP

capitation payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

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

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

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

(2) General coverage exclusions include the following:

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

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

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

(D) Refractions and visual aids.

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

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

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

(H) Non-therapeutic hysterectomy.

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

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

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

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

(M) Physician supervision of hemodialysis or peritoneal dialysis.

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

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

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

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

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(R) Night calls or unusual hours.

(S) Speech and Hearing services.

(T) Mileage.

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

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

(W) Inpatient chemical dependency treatment.

(X) Fertility treatment.

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

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

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not be SoonerCare compensable.

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

(B) Out of state placements will not be authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use

resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

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

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

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

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

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Title 21, Oklahoma Statutes, Section 846, as amended, states in part: *Every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic physicians, residents, and interns, examining, attending, or treating a child under the age*

of eighteen (18) years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of eighteen (18) years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above. Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought as a result of the report.

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

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

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

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

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

(E) Payment to the same physician for both an outpatient

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visit and admission to hospital on the same date.

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

(G) Non-therapeutic hysterectomy.

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

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

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

(K) Physician supervision of hemodialysis or peritoneal dialysis.

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

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

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

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

(P) Night calls or unusual hours.

(Q) Mileage.

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

(S) Tympanometry.

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

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

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

317:30-5-695. Eligible dental providers

(a) Eligible dental providers in Oklahoma's SoonerCare program are:

(1) individuals licensed as dentists under 59 Oklahoma Statutes ' ' 328.21, 328.22, and 328.23 (licensed dentists, specialty dentists and out of state dentists);

(2) individuals issued permits as dental interns under 59 Oklahoma Statute ' 328.26;

(3) individuals who are third and fourth year dental students at an accredited Oklahoma dental college; and

(4) any individual issued a license in another state as a dentist.

(b) All eligible providers must be in good standing with regard to their license. Any revocation or suspension status of a provider referenced in subsection (a) above renders the provider ineligible for payment or subject to recoupment under SoonerCare.

(c) Eligible providers must document and sign records of services rendered in accordance with guidelines found at OAC 317:30-3-15.

Payment is made for dental services as set forth in this Section.

(1) Adults.

(A) Dental coverage for adults is limited to:

(i) emergency extractions;

(ii) Smoking and Tobacco Use Cessation Counseling; and

(iii) medical and surgical services performed by a dentist, to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, when those services would be covered if performed by a physician.

(B) Payment is made for dental care for adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care, similar to the scope of services available to individuals under age 21.

(C) Pregnant women are covered under a limited dental benefit plan (Refer to (a)(4) of this Section).

(2) Home and community based waiver services for the mentally retarded (HCBWS). All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. Dental services are defined in each waiver and must be prior authorized.

(3) Children. The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under 21 years of age without prior authorization. **ALL OTHER DENTAL SERVICES MUST BE PRIOR AUTHORIZED.** Anesthesia services are covered for children in the same manner as adults.

(A) Comprehensive oral evaluation. Comprehensive oral evaluation must be performed and recorded for each new patient, or established patient not seen for more than 18

months. This procedure is allowed once each 18 month period.

(B) **Periodic oral evaluation.** This procedure may be provided for a client of record if she or he has not been seen for more than six months.

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of a periodic oral examination or if the member is involved in active treatment unless trauma or acute infection is the presenting complaint.

(D) **Emergency extractions.** This procedure is only for the relief of pain or treatment of acute infection.

(E) **Oral hygiene instructions.** The dentist or designated qualified dental staff shall instruct the member or the responsible adult, if the child is under five years of age, in proper tooth brushing and flossing by actual demonstration. Verbal and/or written proper diet information should be discussed. This service includes a new tooth brush, disclosing tablets if available, and a small container of six or more yards of dental floss dispensed to the patient when appropriate. This service is limited to once per 12 months.

(F) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be determined as medically necessary by the dentist, of diagnostic quality and taken within the allowable limits of the program. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral.

(G) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on all surfaces to be eligible for this service. This service is available through 18 and is compensable only once per lifetime. Replacement of lost sealants will be at no cost to the OHCA.

(H) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(I) **Composite restorations.**

(i) This procedure is compensable for primary incisors as follows:

(I) tooth numbers O and P to age 4.0 years;

(II) tooth numbers E and F to age 6.0 years;

(III) tooth numbers N and Q to 5.0 years; and

(IV) tooth numbers D and G to 6.0 years.

(ii) The procedure is also allowed for use in all vital and successfully treated non-vital permanent anterior teeth.

(iii) Class I and II composite restorations are allowed in posterior teeth; however, the OHCA has certain restrictions for the use of this restorative material. (See OAC 317:30-5-699).

(J) **Amalgam.** Amalgam restorations are allowed in:

(i) posterior primary teeth when:

(I) 50 percent or more root structure is remaining;

(II) the teeth have no mobility; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) any permanent tooth, determined as medically necessary by the treating dentist.

(K) **Stainless steel crowns.** The use of stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if; the child is five years of age or under and 70 percent or more of the root structure remains or when the tooth would not exfoliate within the next 12 months.

(ii) Stainless steel crowns are treatment of choice for primary teeth with pulpotomies or pulpectomies, if the

above conditions exist, and for primary teeth where three surfaces of extensive decay exist or where cuspal occlusion is lost due to decay or accident.

(iii) Stainless steel crowns are the treatment of choice on posterior permanent teeth that have completed endodontic therapy, if more than three surfaces or cuspal occlusion are lost due to decay prior to age 16.0 years.

(iv) Preoperative periapical x-rays must be available for review, if requested.

(L) Pulpotomies and pulpectomies.

(i) Therapeutic pulpotomies are allowable for molars and teeth numbers listed below. Pre and post operative periapical x-rays must be available for review, if requested.

(I) Primary molars having at least 70 percent or more of their root structure remaining or more than 12 months prior to normal exfoliation;

(II) Tooth numbers O and P before age 5.0 years;

(III) Tooth numbers E and F before 6.0 years;

(IV) Tooth numbers N and Q before 5.0 years; and

(V) Tooth numbers D and G before 6.0 years.

(ii) Pulpectomies are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.

(M) Anterior root canals. Payment is made for the services provided in accordance with the following:

(i) This procedure is done for permanent teeth when there are not other missing anterior teeth in the same arch requiring replacement.

(ii) Acceptable ADA filling materials must be used.

(iii) Preauthorization is required if the member's treatment plan involves more than four anterior root canals.

(iv) Teeth with less than 50 percent of clinical crown should not be treatment-planned for root canal therapy.

(v) Pre and post operative periapical x-rays must be available for review.

(vi) Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA.

(vii) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for 24 month post completion.

(viii) Endodontic treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.

(ix) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.

(N) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than 5mm below the crest of the alveolar ridge or where the successor tooth would not normally erupt in the next 12 months.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal

relationship.

(III) If there are missing teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim should be those of the missing teeth.

(V) Post operative bitewing x-rays must be available for review.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used where multiple missing teeth exist in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age 6.0 years to prevent abnormal swallowing habits.

(IV) Pre and post operative x-rays must be available.

(iii) **Interim partial dentures.** These dentures are used for an anterior permanent tooth replacement or if the member is missing three or more posterior teeth to age 16.0 years.

(O) **Analgesia.** Use of nitrous oxide is compensable for four occurrences per year.

(P) **Pulp caps (direct).** ADA accepted CAOHC containing material must be used.

(Q) **Sedative treatment.** ADA acceptable materials must be used for temporary restoration. This restoration is used for very deep cavities to allow the tooth an adequate chance to heal itself or an attempt to prevent the need for root canal therapy. This restoration, when properly used, is intended to relieve pain and may include a direct or indirect pulp

cap. The combination of a pulp cap and sedative fill is the only restorative procedure allowed per tooth per day. Subsequent restoration of the tooth is allowed after a minimum of 30 days.

(R) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.

(S) **Local anesthesia.** This procedure is included in the fee for all services.

(T) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the patient to describe his/her smoking, advising the patient to quit, assessing the willingness of the patient to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the patient specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(4) **Pregnant Women.** Dental coverage for this special population is provided regardless of age.

(A)Proof of pregnancy is required (Refer to OAC 317:35-5-6).

(B)Coverage is limited to a time period beginning at the diagnosis of pregnancy and ending upon 60 days post partum.

(C)In addition to dental services for adults, other services available include:

(i)Comprehensive oral evaluation must be performed and recorded for each new client, or established client not seen for more than 24 months;

(ii) Periodic oral evaluation as in 317:30-5-696 (a)(3)(B);

(iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an oral examination by the same provider for the same client, or if the client is under active treatment;

(iv) Oral hygiene instructions as in 317:30-5-696 (a)(3)(E);

(v) Radiographs as in 317:30-5-696 (a)(3)(F);

(vi) Dental prophylaxis as in 317:30-5-696 (a)(3)(H);

(vii) Composite restorations:

(I) Any permanent tooth that has an opened lesion that is a food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.

(II) Class I posterior composite resin restorations are allowed in posterior teeth that qualify;

(viii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and

(ix) Analgesia. Use of nitrous oxide is compensable for four occurrences.

(D) Services requiring prior authorization (Refer to OAC 317:30-5-698).

(E) Periodontal scaling and root planing. Required that 50% or more of six point measurements be 4 millimeters or greater. This procedure is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism and requires anesthesia and some soft tissue removal.

(5) Individuals eligible for Part B of Medicare.

(A) Payment is made utilizing the Medicaid allowable for

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comparable services. This is an all inclusive payment on assigned claims.

(B) Services which have been denied by Medicare as noncompensable should be filed directly with this Authority with a copy of the Medicare EOB attached.

317:30-5-696.1. Conscious Sedation

Payment is made for medical and surgical services performed by a dentist to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, when those services would be covered if performed by a physician. Payment is made to Dentists who have received appropriate formal education in conscious (moderate) sedation, deep sedation, and general anesthesia and are qualified to use these modalities in practice.

(1) Training to competency in conscious (moderate) sedation techniques may be acquired at the predoctoral, postgraduate, graduate, or continuing education level. Dentists who wish to utilize conscious (moderate) sedation are expected to successfully complete formal training which is structured in accordance with the American Dental Association's educational guidelines as well as the board of Dentistry for the State in which they practice.

(2) The knowledge and skills required for the administration of deep sedation and general anesthesia are beyond the scope of pre-doctoral and continuing education. Only dentists who have successfully completed an accredited/approved residency program in anesthesiology, for the administration of anesthetic agents will be permitted to provide and bill for this service.

(3) All anesthesia services must be provided in accordance with OAC 317:30-5-7.

317:30-5-698. Services requiring prior authorization

(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis. Emergency dental care is immediate service that must be provided to relieve the recipient from pain due to an acute infection, swelling, trismus or trauma. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. Study models (where indicated), x-rays, six point periodontal charting, comprehensive treatment plan and narrative may be requested. If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense.

(b) Requests for prior authorization are filed on the currently approved ADA form. OHCA notifies the provider on the determination of prior authorization using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.

(d) Listed below are examples of services requiring prior authorization for members under 21 and eligible ICF/MR residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays and periapical films of tooth/teeth involved or the edentulous areas if not visible in the bitewings. X-rays must be mounted so that they are viewed from the front of the member. If required x-rays sent are copies, each film or print must be of good, readable quality and identified as to left and right sides. The film must clearly show the requested service area of interest. X-rays must be identified with member name, date, recipient ID number, provider name, and provider number. X-rays must be placed together in an envelope and stapled to the submission form. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) Endodontics. Pulpotomy may be performed for the relief of

pain while waiting for the decision from the OHCA on request for endodontics.

(A) Anterior root canals. This procedure is for members whom, by the provider's documentation, have a treatment plan requiring more than four anterior root canals and/or posterior endodontics. Payment is made for services provided in accordance with the following:

(i) Permanent teeth numbered 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27 are eligible for therapy if there are not other missing teeth in the same arch requiring replacement, unless numbers 6, 11, 22, or 27 are abutments for prosthesis.

(ii) Accepted ADA filling must be used.

(iii) Pre and post operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor.

(vi) An endodontic procedure may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(vii) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.

(B) Posterior endodontics. The guidelines for this procedure are as follows:

(i) The provider should document that the client has improved oral hygiene and flossing ability in this member's records.

(ii) Teeth that would require pre-fabricated post and cores to minimally retain a crown due to lack of natural

tooth structure should not be treatment planned for root canal therapy.

(iii) Pre and post operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area.

(vi) Only ADA accepted filling materials are acceptable under the OHCA policy.

(vii) Posterior endodontic procedure is limited to a maximum of five teeth. A request may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(viii) Endodontics will not be considered if:

(I) there are missing teeth in the same arch requiring replacement;

(II) an opposing tooth has super erupted;

(III) loss of tooth space is one third or greater;

(IV) opposing second molars are involved; or

(V) the member has multiple teeth failing due to previous inadequate root canal therapy.

(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(x) a single failing root canal is determined not medically necessary for re-treatment.

(2) Cast metal crowns or ceramic-based crowns. This procedure

is compensable for members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for the Mentally Retarded (IF/MR) and who have been approved for IF/MR level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure.

(i) The tooth must be fractured or decayed to such an extent to prevent proper cuspal or incisa function.

(ii) The clinical crown is destroyed by the above elements by one-half or more.

(iii) Endodontically treated teeth must have three or more surfaces restored or lost due to carious activity to be considered.

(B) The conditions listed in (A)(I) through (A)(iii) of this paragraph should be clearly visible on the submitted x-rays when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleansable margins, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed.

(E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.

(F) Ceramic-metal based crowns will be considered only for tooth numbers 4 through 13 and 21 through 28.

(G) Full cast metal crowns are treatment of choice for all posterior teeth.

(H) Provider is responsible for replacement or repair of cast crowns for 48 months post insertion.

(3) Cast frame partial dentures. This appliance is the treatment of choice for replacement of three or more missing permanent teeth in the same arch for members 16 through 20 years

of age. Provider must indicate tooth number to be replaced and teeth to be clasped.

(4) Acrylic partial. This appliance is the treatment of choice for replacement of missing anterior permanent teeth or three or more missing teeth in the same arch for members 12 through 16 years of age and adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care. Provider must indicate tooth numbers to be replaced and teeth to be clasped. This appliance includes all necessary clasps and rests.

(5) Fixed cast non-precious metal or porcelain/metal bridges. Only members 17 through 20 years of age where the bite relationship precludes the use of an acrylic or cast frame partial denture are considered. Study models with narrative are required to substantiate need for fixed bridge(s). Members must have excellent oral hygiene documented in the requesting provider's records.

(6) Periodontal scaling and root planing. This procedure requires that 50% or more of six point measurements be four millimeters or greater. This procedure is allowed on members 12 to 20 and requires anesthesia and some soft tissue removal occurs. Tooth planing is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism.

(7) Additional prophylaxis. The OHCA recognizes that certain physical conditions require more than two prophylaxes. The following conditions may qualify a member for one additional prophylaxis per year:

- (A) dilantin hyperplasia;
- (B) cerebral palsy;
- (C) mental retardation;
- (D) juvenile periodontitis.

317:30-5-1076. Coverage by category

Payment is made for Nutritional Services as set forth in this section.

(1) **Adults.** Payment is made for six hours of medically necessary nutritional counseling per year by a licensed registered dietician. All services must be prescribed by a physician, physician assistant, nurse practitioner or nurse midwife and be face to face encounters between a licensed registered dietitian and the member. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness.

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

(3) **Home and Community Based Waiver Services for the Mentally Retarded.** All providers participating in the Home and Community Based Waiver Services for the Mentally Retarded program must have a separate contract with OHCA to provide Nutrition Services under this program. All services are specified in the individual=s plan of care.

(4) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Services which are not covered under Medicare should be billed directly to OHCA.

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

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

(1) have no more than a total of 50 employees on its payroll. The number of employees is determined based on the third month employee count of the most recently filed OES-3 form with the Oklahoma Employment Security Commission (OESC) and that is in compliance with all requirements of the OESC. Employers may provide additional documentation confirming terminated or part time employees that will be excluded from the OESC employee count. If the employer is exempt from filing an OES-3 form or is contracted with a PEO or is a Child Care Center, in accordance with OHCA rules, this determination is based on appropriate supporting documentation, such as the W-2 Summary Wage and Tax form as required under OAC 365:10-5-156 to verify employee count;

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

(3) be currently offering or intending to offer within 90 calendar days an O-EPIC Qualified Health Plan. The Qualified Health Plan coverage must begin on the first day of the month and continue through the last day of the month;

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

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

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

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

(d) The employer must notify the TPA, within 5 working days from occurrence, of any O-EPIC employee's termination or resignation.

317:45-7-2. Employer eligibility determination

Eligibility for employers is determined by the TPA using the eligibility requirements listed in OAC 317:45-7-1. An employer determined eligible for O-EPIC is approved for up to a 12 month period. The eligibility period begins on the first day of the month following the date of approval. The eligibility period ends the last day of the 12th month. The eligibility period will renew automatically unless the employer's eligibility has been closed (refer to OAC 317:45-7-8). The TPA notifies the employer of the eligibility decision for employer and employees.

317:45-7-8. Closure

Eligibility provided under the O-EPIC program ends during the eligibility period when:

- (1) the employer terminates its contract with all Qualified Health Plans;
- (2) the employer fails to pay premiums to the Carrier;
- (3) the employer fails to provide an invoice verifying the monthly health plan premium has been paid;
- (4) an audit indicates a discrepancy that makes the employer ineligible;
- (5) the employer no longer has a business location in Oklahoma;
or
- (6) the Qualified Health Plan or Carrier no longer qualifies for O-EPIC.

317:45-11-10. O-EPIC IP benefits

(a) All O-EPIC IP benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this Section.

(b) A PCP referral is required to see any other provider with the exception of the following services:

(1) behavioral health services;

(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;

(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;

(4) women's routine and preventive health care services;

(5) emergency medical condition as defined in OAC 317:30-3-1; and

(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

(c) O-EPIC IP covered benefits, limits, and applicable co-payments are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of \$1,000,000. Coverage includes:

(1) Anesthesia / Anesthesiologist Standby. Covered in accordance with OAC 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA).

(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.

(3) Chelation Therapy. Covered for heavy metal poisoning only.

(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with OAC 317:30-5-22(b)(2). PCP referral is required. Standard radiology (X-ray or Ultrasound): \$0 co-pay.

Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan); \$25 co-pay per scan.

(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a \$30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.

(6) Inpatient Hospital Benefits. Covered in accordance with OAC 317:30-5-41, 317:30-5-47 and 317:30-5-95; \$50 co-pay per admission.

(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year with a \$10 co-pay. This visit counts as an office visit.

(8) Office Visits/Specialist Visits. Covered in accordance with OAC 317:30-5-9, 317:30-5-10, and 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits; \$10 co-pay per visit.

(9) Outpatient Hospital/Facility Services.

(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures; \$25 co-pay per visit.

(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections; \$10 co-pay per visit.

(10) Maternity (Obstetric). Covered in accordance with OAC 317:30-5-22. Nursery care paid separately under eligible child; \$50 inpatient hospital co-pay.

(11) Laboratory/Pathology. Covered in accordance with OAC 317:30-5-20; \$0 co-pay.

(12) Mammogram (Radiological or Digital). Covered in accordance with OAC 317:30-5-901; \$0 co-pay.

(13) Immunizations for Adults. Covered in accordance with OAC 317:30-5-2; \$10 co-pay per immunization.

(14) Assistant Surgeon. Covered in accordance with OAC 317:30-5-8.

(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility; \$0 co-pay.

(16) Oral Surgery. Services are limited to the removal of tumors or cysts; Inpatient Hospital \$50 or Outpatient Hospital/Facility; \$25 co-pay applies.

(17) Mental Health Treatment (Inpatient). Covered in accordance with OAC 317:30-5-95.1; \$50 co-pay per admission.

(18) Mental Health Treatment (Outpatient). Covered in accordance with OAC 317:30-5-241; \$10 co-pay per visit.

(19) Substance Abuse Treatment (Outpatient). Covered in accordance with OAC 317:30-5-241; \$10 co-pay per visit.

(20) Durable Medical Equipment and Supplies. Covered in accordance with OAC 317:30-5, Part 17. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a \$15,000 annual maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy; \$5 co-pay for durable/non-durable supplies and \$25 co-pay for durable medical equipment.

(21) Diabetic Supplies. Covered in accordance with OAC 317:30-5, Part 17; not subject to \$15,000 annual DME limit; \$5 co-pay per prescription.

(22) Oxygen. Covered in accordance with OAC 317:30-5, Part 17; not subject to \$15,000 annual DME limit; \$5 co-pay per month.

(23) Pharmacy. Covered in accordance with OAC 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits; \$5/\$10 co-pay per prescription.

(24) Smoking Cessation Products. Products do not count against

monthly prescription limits. Covered in accordance with OAC 317:30-5-77.2; \$5/\$10 co-pay per product.

(25) Nutrition Services. Covered in accordance with OAC 317:30-5-1076; \$10 co-pay per visit.

(26) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with OAC 317:30-5, Part 17; \$25 co-pay per prosthesis.

(27) Surgery. Covered in accordance with OAC 317:30-5-8; \$50 co-pay per inpatient admission and \$25 co-pay per outpatient visit.

(28) Home Dialysis. Covered in accordance with OAC 317:30-5, Part 17; not subject to \$15,000 annual DME limit; \$0 co-pay.

(29) Parenteral Therapy. Covered in accordance with OAC 317:30-5, Part 17; not subject to \$15,000 annual DME limit; \$25 co-pay per month.

(30) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with OAC 317:30-3-57; \$0 co-pay.

(31) Home Health Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with OAC 317:30-5-211(a)(3)(D)(i) and 317:30-5-41(2)(J)(iii).

(32) Ultraviolet Treatment-Actinotherapy.

(33) Fundus photography.

317:45-11-11. O-EPIC IP non-covered services

Certain health care services are not covered in the O-EPIC IP benefit package listed in OAC 317:45-11-10. These services include, but are not limited to:

(1) services that the member's PCP or O-EPIC does not consider medically necessary;

(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;

(3) organ and tissue transplant services;

(4) treatment of obesity;

(5) procedures, services and supplies related to sex transformation;

(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;

(7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);

(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;

(9) experimental procedures, drugs or treatments;

(10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident);

(11) vision care and services (including glasses), except services treating diseases or injuries to the eye;

(12) physical medicine including speech, physical, occupational, chiropractic, acupuncture and osteopathic manipulation therapy;

(13) hearing services;

(14) transportation [emergent or non-emergent (air or ground)];

(15) rehabilitation (inpatient);

- (16) cardiac rehabilitation;
- (17) allergy testing and treatment;
- (18) home health care with the exception of medications, intravenous (IV) therapy, supplies;
- (19) hospice regardless of location;
- (20) Temporomandibular Joint Dysfunction (TMD) (TMJ);
- (21) genetic counseling;
- (22) fertility evaluation/treatment/and services;
- (23) sterilization reversal;
- (24) Christian Science Nurse;
- (25) Christian Science Practitioner;
- (26) skilled nursing facility;
- (27) longterm care;
- (28) stand by services;
- (29) thermograms; and
- (30) abortions (for exceptions, refer to OAC 317:30-5-6).