
POLICY TRANSMITTAL NO. 07-50	DATE: AUGUST 16, 2007
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 317:30-3-5.1; 30-3-57; 30-5-2; 30-5-23; 30-5-41.2; 30-5-175 through 30-5-176; 30-5-178; 30-5-185 through 30-5-188; 30-5-190 through 30-5-193; 30-5-195 through 30-5-199; 30-5-201; 30-5-321; 30-5-322; 30-5-375; 30-5-910 through 30-5-911, 30-5-913, 30-5-920 through 30-5-921; 30-5-923 through 30-5-924; and 30-5-1150 through 30-5-1161.

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

Rules are revised to instruct providers to bill their usual and customary charges when billing the SoonerCare program.
Physicians rules regarding billing for newborn care are revised to remove obsolete procedure's language.
Rules are revised to allow coverage for organ donor expenses for SoonerCare member transplants.
Room and Board Provider rules are revised to delete procedure codes, allowable amounts and obsolete form numbers.
Advanced Practice Nurse rules are revised to correct an inaccurate reference citation to Oklahoma Board of Nursing rules.
Rules are revised to define services that the Oklahoma State Department of Health (OSDH) as County Health Department's (CHD) and City-County Health Departments (CCHDs) provide and the manner that they provide these services. Revisions will consolidate all rules pertaining to CHD's and CCHD's.

Original signed on 8-15-07

Mary Stalnaker, Director
Family Support Services Division

Sharon Neuwald, Coordinator
Office of Legislative Relations and Policy

WF # 07-U (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>
-----	317:30-3-5.1, 1 page only, issued 6-25-07
317:30-3-57	317:30-3-57, pages 1-5, revised 6-25-07
317:30-5-2	317:30-5-2, pages 1-10, revised 6-25-07
317:30-5-23	317:30-5-23, 1 page only, revised 6-25-07
-----	317:30-5-41.2, 1 page only, issued 6-25-07
317:30-5-175	-----
317:30-5-176	-----
317:30-5-178	-----
317:30-5-185	-----
317:30-5-186	-----
317:30-5-187	-----
317:30-5-188	-----
317:30-5-190	-----
317:30-5-191	-----
317:30-5-192	-----
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317:30-5-195

317:30-5-196

317:30-5-197

317:30-5-198

317:30-5-199

317:30-5-201

317:30-5-321

317:30-5-321, 1 page only, revised 6-25-07

317:30-5-322

317:30-5-375

317:30-5-375, 1 page only, revised 6-25-07

317:30-5-910

317:30-5-911

317:30-5-913

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317:30-5-921

317:30-5-923

317:30-5-924

317:30-5-1150, 1 page only, issued 6-25-07

317:30-5-1151, 1 page only, issued 6-25-07

317:30-5-1152, 1 page only, issued 6-25-07

317:30-5-1153, 1 page only, issued 6-25-07

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317:30-5-1155, 1 page only, issued 6-25-07

317:30-5-1156, 1 page only, issued 6-25-07

317:30-5-1157, 1 page only, issued 6-25-07

317:30-5-1158, 1 page only, issued 6-25-07

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317:30-5-1159, pages 1-3, issued 6-25-07

317:30-5-1160, 1 page only, issued 6-25-07

317:30-5-1161, 1 page only, issued 6-25-07

317:30-3-5.1. Usual and Customary fees

(a) Providers are required to indicate their usual and customary charge when submitting claims to SoonerCare. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to SoonerCare benefits. For providers using a sliding fee scale, the usual and customary charge is the one that best represents the most frequently charged amount by the individual provider for the service when provided to non-SoonerCare members. Providers that do not have an established usual and customary charge should indicate an amount reasonably related to the provider's cost for providing the service.

(b) Providers may not charge SoonerCare a higher fee than they charge non-SoonerCare patients even if the SoonerCare allowable is greater than the provider's usual and customary fee. Unless otherwise permitted by SoonerCare reimbursement methodology, individual claim payments will be limited to the lesser of their usual and customary charge or the SoonerCare allowable.

(c) Providers should indicate their usual and customary charge without deducting the co-payment for services that require a member co-payment. When applicable, the co-payment will be systematically deducted.

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

The following are general SoonerCare coverages for the categorically needy:

- (1) Inpatient hospital services other than those provided in an institution for mental diseases.
 - (A) Adult coverage for inpatient hospital stays as described at OAC 317:30-5-41.
 - (B) Coverage for members under 21 years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.
- (2) Emergency department services.
- (3) Dialysis in an outpatient hospital or free standing dialysis facility.
- (4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.
- (5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with OHCA.
- (6) Outpatient Mental Health Services for medical and remedial care including services provided on an outpatient basis by certified hospital based facilities that are also qualified mental health clinics.
- (7) Rural health clinic services and other ambulatory services furnished by rural health clinic.
- (8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.
- (9) Maternity Clinic Services.
- (10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.
- (11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.
- (12) Nursing facility services (other than services in an institution for tuberculosis or mental diseases).
- (13) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under 21 years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services.

These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA Child Health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.4.

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

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

(C) Immunizations.

(D) Outpatient care.

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

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

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

(H) Prescribed drugs.

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

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

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

(L) Inpatient hospital services.

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

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

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

(15) Family planning centers.

(16) Physicians' services whether furnished in the office, the

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

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

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

(18) Free-standing ambulatory surgery centers.

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

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

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

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

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

(22) Dental services for members residing in private ICF/MR's in accordance with the scope of dental services for members under age 21.

(23) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation

and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.

(24) Standard medical supplies.

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

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

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

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

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

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

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

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

(33) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a R.N.

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

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

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

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

- (A) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.
- (B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.
- (C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.
- (D) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.
- (E) Finally, procedures considered experimental or investigational are not covered.
- (38) Home and community-based waiver services for mentally retarded members who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).
- (39) Case Management services for the chronically and/or severely mentally ill.
- (40) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.
- (41) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.
- (42) Early Intervention services for children ages 0-3.
- (43) Residential Behavior Management in therapeutic foster care setting.
- (44) Birthing center services.
- (45) Case management services through the Oklahoma Department of Mental Health and Substance Abuse.
- (46) Home and Community-Based Waiver services for aged or physically disabled members.
- (47) Outpatient ambulatory services for members infected with tuberculosis.
- (48) Smoking and Tobacco Use Cessation Counseling for children and adults.
- (49) Services delivered to American Indians/Alaskan Natives in I/T/Us. Payment is made on an encounter basis.

317:30-5-2. 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 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.

(K) Obstetrical care.

(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.
- (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 adult 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.

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OAC 317:30-5-2 (p4)

- (iv) Procedures considered experimental or investigational are not covered.
- (AA) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.
- (i) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure.
- (ii) Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.
- (BB) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.
- (CC) Ventilator equipment.
- (DD) Home dialysis equipment and supplies.
- (EE) 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.
- (FF) 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.

(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.

(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.)

(R) Night calls or unusual hours.

(S) Speech and Hearing services.

(T) Mileage.

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

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

(W) Inpatient chemical dependency treatment.

(X) Fertility treatment.

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

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

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

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

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

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

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

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

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

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Title 21, Oklahoma Statutes, Section 846, as amended, states in part:

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

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

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

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

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

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

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

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

(G) Non-therapeutic hysterectomy.

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OAC 317:30-5-2 (p9)

(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

**MEDICAL PROVIDERS-FEE FOR SERVICE
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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.

317:30-5-23. Newborn care

Claims for newborn care and circumcision are filed under the newborn's SoonerCare member ID number.

(1) When there is a newborn child and the mother is receiving SoonerCare benefits, an OKDHS form 08MA015E (FSS-NB-1) or other notification must be submitted to the county OKDHS office. If the mother is not already receiving SoonerCare benefits, an application will need to be completed. Services are billed using the appropriate codes contained in the Physician's Current Procedural Terminology (CPT).

(2) Neonatal intensive care codes (contained in the CPT) are used to report neonatal intensive care services. Certain procedures are bundled into the relevant inpatient neonatal critical care evaluation and management codes and are not reimbursed separately. All other medically-necessary procedures provided are considered for reimbursement using recognized coding and/or editing logic. Additional payment is allowed for standby at Cesarean Section, attendance at delivery or newborn resuscitation.

(3) Payment may be made for an evaluation and management service and newborn circumcision provided by the same provider on the same date of service.

317:30-5-41.2. Organ transplants

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

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

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

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

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

(5) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

317:30-5-321. Coverage by category

Payment is made to Room and Board Providers as set forth in this Section.

(1) **Adults.** Payment is made to Room and Board Providers for room and board of an eligible adult and an escort, if necessary, when authorized by OHCA. Room and Board is authorized by, Room and Board Order form, for Adults and Children. A copy of the authorization must be attached to each claim along with the dates of stay and signature of authorized escort.

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

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

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

317:30-5-375. Eligible providers

The Advanced Practice Nurse must be a registered nurse in good standing with the Oklahoma Board of Nursing, and have acquired knowledge and clinical skills through the completion of a formal program of study approved by the Oklahoma Board of Nursing Registration and have obtained professional certification through the appropriate National Board recognized by the Oklahoma Board of Nursing. Advanced Practice Nurse services are limited to the scope of their practice as defined in 59 O.S. 567.3a and corresponding rules and regulations at OAC 485:10-5-1 through 10-16-9. Rules regarding Nurse Midwives are referenced in OAC 317:30-5-225. Advanced Practice Nurses who practice in states other than Oklahoma must be appropriately licensed in the state in which they practice.

In addition, all providers must have a current contract on file with the Oklahoma Health Care Authority.

**MEDICAL PROVIDERS-FEE FOR SERVICE
PUBLIC HEALTH CLINIC SERVICES**

OAC 317:30-5-1150

317:30-5-1150. General

Public Health Clinic services consist of primary and preventive health care, related diagnostic services, and/or dental services. County health departments (CHDs) and City-County Health Departments (CCHDs) may participate as providers in the SoonerCare program as Public Health Clinics. The Statutory basis for their participation is pursuant to 42 CFR 431.615 (Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees), thereby implementing Sec. 1902(a)(11) and (22)(C) of the Social Security Act. The CHD Clinics are administered by the Oklahoma State Department of Health (OSDH) for the purpose of providing public health services.

317:30-5-1151. Eligible providers

To be eligible for reimbursement, a CHD or the OSDH (on behalf of the CHDs) or CCHD, must complete a provider contract with the Oklahoma Health Care Authority (OHCA). The CHD or CCHD clinic must have a licensed physician on staff or physician supervising the services. The supervising physician must be available at all times in person or by direct telecommunication for advice and assistance on patient referrals or emergencies. Clinic services must be provided in accordance with 42 CFR 440.90.

317:30-5-1152. Provider participation requirements

(a) OSDH and or/ CHD or CCHD must employ or contract the services of professional staff that are authorized within their scope of practice under state law to provide the services for which claims are submitted to the OHCA.

(b) The OSDH and CCHDs are required to submit a list of names of all practitioners who are working within the CHD and not individually enrolled with the OHCA when requested by the OHCA or it's designated agent.

**MEDICAL PROVIDERS-FEE FOR SERVICE
PUBLIC HEALTH CLINIC SERVICES**

OAC 317:30-5-1153

317:30-5-1153. Physician

Physicians who perform services in Oklahoma, but who are not licensed in Oklahoma may provide services for the CHD/CCHD if they are commissioned medical officers of the Public Health Service or Armed Services of the United States, on active duty, and acting within the scope of their Public Health Service or military responsibilities.

317:30-5-1154. CHD/CCHD services/limitations

CHD/CCHD service limitations are:

- (1) Child Guidance services (see OAC 317:30-3-65 through OAC 317:30-3-5-65.11 for specifics regarding program requirements).
- (2) Dental services [OAC 317:30-3-65.4(7)].
- (3) Early Periodic Screening, Diagnosis, and Treatment services (including blood lead testing and follow-up services) (see OAC 317:30-3-65 through OAC 30-3-65.11 for specific coverage).
- (4) Environmental investigations.
- (5) Family Planning services and Family Planning Waiver Services (see OAC 317:30-5-465 through OAC 317:30-5-467 for specific coverage and limitations).
- (6) Immunizations (adult and child).
- (7) Blood lead testing (see OAC 317:30-3-65.4 for specific coverage).
- (8) Newborn hearing screening.
- (9) Newborn metabolic screening.
- (10) Maternity services (see OAC 317:30-5-22 for specific coverage).
- (11) Public health nursing services.
- (12) Tuberculosis case management and directly observed therapy.
- (13) Laboratory services.
- (14) Targeted case management.

317:30-5-1155. Immunizations

(a) Immunizations are administered in accordance with Centers for Disease Control, Advisory Committee on Immunization Practices.

(b) The Vaccines for Children (VFC) program offers free vaccines to qualified health care providers for children 18 years of age and under who are Soonercare members, American Indian or Alaska Native, uninsured, or under insured. The Oklahoma State Department of Health administers this program.

317:30-5-1156. Environmental lead investigations

Environmental inspections are provided through the Oklahoma State Department of Health (OSDH) upon notification from laboratories or providers and reimbursed through the Oklahoma SoonerCare program. The OCLPPP schedules an environmental inspection to identify the source of the lead for children who have a persistent blood lead level 15 ug/dL or greater. After the results of the environmental inspection have been received, the OHCA and OCLPPP continue case management activities until two consecutive blood lead measurements equal to or below 10 ug/dL have been achieved. A qualified investigator must be certified, accredited or granted approval by the Oklahoma Department of Environmental Quality to perform environmental lead testing.

317:30-5-1157. Newborn screening

(a) The newborn hearing screening is for the purpose of testing all newborns for hearing impairments to alleviate the adverse effects of hearing loss or speech and language development. The screening is a test or battery of tests administered to determine the need for an in-depth hearing diagnostic evaluation. Payment for the initial screening is included in the inpatient facility payment. Follow-up screening is covered if the child has not been seen by his/her PCP/CM.

(b) The newborn metabolic screening is for the purpose of testing all newborns born in Oklahoma for disorders as determined by the OSDH Board of Health. Short-term and long-term follow-up services are provided in conjunction with the laboratory testing.

317:30-5-1158. Public health nursing services

(a) Public health nursing services must be performed at a main clinic site, satellite clinic or mobile clinic site that is open to the public, or a member's home.

(b) Clinic visits may include but are not limited to services in the following areas:

(1) health promotion and counseling;

(2) medication management;

(3) nursing assessment, treatment and diagnostic testing;

(4) home visits;

(5) nursing treatments;

(6) immunizations;

(7) administration of injectable medications;

(8) medication management and the direct observation of the intake of prescribed drugs to treat tuberculosis (TB); and

(9) case management for TB, first time mothers and their infant children, and high risk pregnant women.

317:30-5-1159. Tuberculosis

The purpose of the Tuberculosis program is to identify and treat clients with tuberculosis, insure appropriate measures are taken to prevent the occurrence and transmission of tuberculosis, analyze tuberculosis related data for program planning and evaluation, and ultimately eliminate tuberculosis in Oklahoma. Payment is made for tuberculosis clinic services pursuant to (1) - (7) of this Section.

(1) **Nursing visit - regular with disease.** Nursing visit - regular with disease requires an initial intensive interview by Health Department personnel for gathering clinical and epidemiologic data and administration of a tuberculosis skin test.

(A) The nursing visit in this paragraph includes:

(i) one x-ray every two months;

(ii) a monthly blood test;

(iii) one series (3 samples) of sputum tests every two months;

(iv) monitoring of side effects; and

(v) provision of medication.

(B) Notification and consultation with the Tuberculosis Control Officer must be established and maintained during the treatment regimen as required by State law.

(C) The nursing visit in this paragraph is appropriate for a patient with the disease of tuberculosis that is drug susceptible and a treatment regimen of six to 12 months is prescribed.

(2) **Nursing visit - multi-drug resistant with disease.** A nursing visit - multi-drug resistant with disease requires an initial intensive interview by Health Department personnel for gathering clinical and epidemiologic data and administration of a tuberculosis skin test.

(A) This nursing visit in this paragraph includes:

(i) one x-ray every two months;

(ii) a monthly blood test;

(iii) one series (3 samples) of sputum tests each month;

(iv) monitoring of side effects; and

(v) provision of medication.

(B) Notification and consultation with the Tuberculosis Control Officer must be established and maintained during the treatment regimen as required by State law.

(C) The nursing visit in this paragraph is appropriate for a patient with the disease of tuberculosis that is multi-drug resistant and a treatment regimen of 18 to 24 months has been prescribed.

(3) Nursing visit - regular preventive therapy with infection.
A nursing visit - regular preventive therapy with infection requires an initial intensive interview by Health Department personnel for gathering clinical and epidemiologic data and administration of a tuberculin skin test.

(A) The nursing encounter in this paragraph includes:

- (i) one x-ray every three months;
- (ii) four blood tests in six months;
- (iii) one series (3 samples) of sputum tests;
- (iv) monitoring of side effects; and
- (v) provision of medication.

(B) Notification and consultation with the Tuberculosis Control Officer must be established and maintained during the treatment regimen as required by State law.

(C) The nursing visit in this paragraph is appropriate for a patient with an infection of drug susceptible tuberculosis and a treatment regimen of 12 months has been prescribed.

(4) Nursing visit - multi-drug resistant preventive therapy with infection.
A nursing visit - multi-drug resistant preventive therapy with infection requires an initial intensive interview by Health Department personnel for gathering clinical and epidemiologic data and administration of a tuberculin skin test.

(A) The nursing visit in this paragraph includes:

- (i) one x-ray every two months;
- (ii) eight blood tests in 12 months;
- (iii) two series (6 samples) of sputum tests each 12 months;
- (iv) monitoring of side effects; and
- (v) provision of medication.

(B) Notification and consultation with Tuberculosis Control Officer must be established and maintained during the treatment regimen as required by State law.

(C) The nursing visit in this paragraph is appropriate for a patient with a multi-drug resistant tuberculosis infection and a treatment regimen of 12 months has been prescribed.

(5) Nursing visit - other.
A nursing visit - other - requires an interview by Health Department personnel for gathering clinical data. This nursing visit may include an x-ray, blood test, sputum sample and monitoring of side effects. It does not include medication. Consultation with the Tuberculosis Control Officer may be required. This visit may be appropriate for either a patient with a tuberculosis infection or disease if the patient is continuing to experience symptoms or on orders of a physician.

(6) **Screening.** In a TB screening, Health Department personnel perform tuberculin skin testing of contacts to all TB cases and suspects, high risk population groups and nursing home residents. Tuberculin skin testing is always done at least one time. For negative skin tests, a two-step boosted skin test one to two weeks later will be performed and repeated three months later for contact individuals with a negative boosted skin test.

(7) **Direct Observed Therapy (DOT).** The DOT provider delivers medication to the patient and observes and records the patient's ingestion of medication. Visits may be as frequent as three times a day, seven days a week. The DOT provider is responsible for monitoring side effects of medication and the collection of sputum samples.

317:30-5-1160. Public health nursing services for first time mothers and their infants/children (Children's First program)

(a) The purpose of the Children's First program is to make home visits to low income, first time parents teaching them about pregnancy, nutrition, fetal development and how to care for themselves and their baby after delivery. A first time mother is:

(1) a woman who is expecting her first live birth, has never parented and plans on parenting this child;

(2) a woman who is expecting her first live birth, has never parented and is contemplating placing the child for adoption;

(3) a woman who has been pregnant, but has not delivered a child due to abortion or miscarriage;

(4) a woman who is expecting her first live birth, but has parented stepchildren or younger siblings;

(5) a woman who has delivered a child, but her parental rights were legally terminated within the first few months of that child's life; or

(6) a woman who has delivered a child, but the child died within the first few months of life.

(b) The pregnant woman must enter the program prior to the 28th week of gestation. Services may be provided until the infant's/child's second birthday.

(c) Reimbursement is limited to one nursing service per day provided during the pre and postnatal period of the first time mother and for the first two years of the infant's/child's life. Public health nurse clinic services are limited to five services per month per eligible member/child.

317:30-5-1161. Targeted case management

(a) Case management is a set of interrelated activities under which responsibility for locating, coordinating and monitoring appropriate services for an individual rests with a specific person within the case management agency. Services under case management are not comparable in amount duration and scope.

(b) Case management is designed to assist a individual in gaining access to needed medical, social, educational and other services essential to meeting basic human needs, and is not restrictive in nature.

(c) Major components of the services include working with the individual in the use of basic community resources, referral, linkage and advocacy.

(d) In order to ensure that case management services are not duplicated by other staff, case management activities will be provided in accordance with a comprehensive individualized treatment/service plan. The development of this plan includes clinical staff participation, thus ensuring that staff knows a client has a case manager.

(e) Case management services for first time mothers must provide necessary coordination with providers of non-medical services, such as nutrition, psycho social or health education programs, when services provided by these entities are needed. The case manager coordinates these services with needed medical services. The purpose of case management services for first time mothers and their infants/children is to:

(1) assist first time mothers and their infants/children in gaining access to needed medical, social, educational and other services;

(2) encourage the use of appropriate medical providers; and

(3) discourage over utilization or duplication of services.

(f) Targeted case management does not include:

(1) SoonerCare eligibility determinations and re-determinations;

(2) SoonerCare intake processing;

(3) SoonerCare preadmission screening for inpatient care;

(4) Prior Authorization for SoonerCare services and utilization review;

(5) SoonerCare outreach;

(6) physically escorting or transporting a member to scheduled appointments or staying with a member during an appointment;

(7) monitoring financial goals;

(8) providing specific services such as shopping or payment of bills; or

(9) delivering bus tickets, food stamps, money, etc.