
POLICY TRANSMITTAL NO. 05-54	DATE: DECEMBER 21, 2005
FAMILY SUPPORT SERVICES DIVISION/OKLAHOMA HEALTH CARE AUTHORITY	DEPARTMENT OF HUMAN SERVICES OFFICE OF PLANNING, POLICY & RESEARCH

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-3-5; 30-3-59; 30-5-2; 30-5-9; 30-5-41; 30-5-47; 30-5-47.2 through 30-5-47.5; 30-5-48; 30-5-110 through 30-5-114; 30-5-122; 30-5-225; 30-5-335; 30-5-336; 30-5-342; 30-5-343; and 30-5-375.

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

Hospital rules are revised to modify the acute inpatient hospital services reimbursement from a level of care per diem system to a diagnosis Related Group (DRG) reimbursement system. Under a DRG system, each case is categorized into a diagnosis related group (DRG). Payments to freestanding psychiatric facilities, freestanding rehabilitation hospitals, and children's long term care hospitals will continue to be paid under the per diem system. Payments for graduate medical education (GME) are excluded from this system. Proposed rule revisions for outpatient hospital reimbursement includes payment for emergency room visits, clinic fees, and observation, based on a hospital's trauma level of care classification as determined by the Oklahoma State Department of Health.

Long term care facilities rules are revised to increase the Medicaid payment for Part A coinsurance for Medicare covered skilled nursing facility care for dually eligible individuals.

Nurse midwives and advanced practice nurses rules are revised to clarify provider requirements for providers who practice in states other than Oklahoma.

Ambulance rules are revised to add coverage by stretcher service, clarify coverage issues, and allow for the adoption of the payment methodology currently utilized by Medicare.

Original signed On 12-21-05

Mary Stalnaker, Director
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Sharon Neuwald, Co-Interim Administrator
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WF # 05-GG (DT)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

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

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, DHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, DHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at (405) 521-3611.

REMOVE

INSERT

317:30-3-5

317:30-3-5, pages 1-4, revised 10-03-05

317:30-3-59

317:30-3-59, pages 1-2, revised 10-03-05

317:30-5-2

317:30-5-2, pages 1-15, revised 10-03-05

317:30-5-9

317:30-5-9, pages 1-4, revised 10-03-05

317:30-5-41

317:30-5-41, pages 1-10, revised 10-03-05

317:30-5-47

317:30-5-47, pages 1-2, revised 10-03-05

317:30-5-47.2, pages 1-4, issued 10-03-05

317:30-5-47.3, 1 page only, issued 10-03-05

317:30-5-47.4, pages 1-3, issued 10-03-05

317:30-5-47.5, 1 page only, issued 10-03-05

317:30-5-48

317:30-5-110, 1 page only, issued 10-03-05

317:30-5-111, pages 1-2, issued 10-03-05

317:30-5-112, 1 page only, issued 10-03-05

317:30-5-113, 1 page only, issued 10-03-05

317:30-5-114, 1 page only, issued 10-03-05

REMOVE

317:30-5-122

317:30-5-225

317:30-5-335

317:30-5-336

317:30-5-342

317:30-5-343

317:30-5-375

INSERT

317:30-5-122, 1 page only, revised 10-03-05

317:30-5-225, 1 page only, revised 10-03-05

317:30-5-335, 1 page only, revised 10-3-05

317:30-5-336, pages 1-5, revised 10-03-05

317:30-5-343, 1 page only, revised 10-03-05

317:30-5-375, 1 page only, revised 10-03-05

317:30-3-5. Assignment and Cost Sharing

(a) **Definitions.** The following words and terms, when used in subsection (c) of this Section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Fee-for-service contract"** means the provider agreement specified in OAC 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority and medical providers which provides for a fee with a specified service involved.

(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the Primary Care Case Manager contracts in the SoonerCare Program.

(3) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the Primary Care Case Manager contracts in the SoonerCare Program.

(b) **Assignment in fee-for-service.** The Authority's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or copayment required by the State Plan to be paid by the recipient and make no additional charges to the patient or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the patient must not be billed and the patient is not responsible for any balance except the amount indicated by OHCA. The only amount a patient may be responsible for is the personal participation as agreed to at the time of determination of eligibility, or the patient may be responsible for services not covered under the medical programs. The amount of personal participation will be shown on the OHCA notification of eligibility. In any event, the patient should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Customer Services.

(3) When potential assignment violations are detected, the

Authority will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the Authority is required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a fee for service contract and also executes a contract with a provider in the Primary Care Case Management program shall adhere to the rules of this subsection regarding assignment.

(1) If the service provided to the recipient is within the scope of the services outlined in the SoonerCare Contract, the recipient shall not be billed for the service. In this case, the provider shall pursue collection from the Primary Care Physician in the case of the SoonerCare Program.

(2) If the service provided to the recipient is outside of the scope of the services outlined in the SoonerCare Contract, then the provider may bill or seek collection from the recipient.

(3) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) and (2) of this subsection, the Oklahoma Health Care Authority shall be the final authority for this decision. The provider seeking payment under the SoonerCare Program may appeal to OHCA under the provisions of OAC 317:2-1-2.1.

(4) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.

(d) **Cost Sharing-Copayment.** Section 1902(a)(14) of the Social Security Act permits states to require certain recipients to share some of the costs of Medicaid by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, copayments, or similar cost sharing charges. OHCA requires a copayment of some Medicaid recipients for certain medical services provided through the fee for service program. A copayment is a charge which must be paid by the recipient to the service provider when the service is covered by Medicaid. Section 1916(e) of the Act requires that a provider participating in the Medicaid program may not deny care or services to an eligible individual based on such individual's inability to pay the copayment. A person's assertion of their inability to pay the copayment establishes this inability. This rule does not change the fact that a recipient is liable for these charges and it does not preclude the provider from attempting to

collect the copayment.

(1) Copayment is not required of the following recipients:

(A) Individuals under age 21. Each recipient's date of birth is available on the REVS system or through a commercial swipe card system.

(B) Recipients in nursing facilities and intermediate care facilities for the mentally retarded.

(C) Pregnant women.

(D) Home and Community Based Waiver service recipients except for prescription drugs.

(2) Copayment is not required for the following services:

(A) Family planning services. Includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(3) Copayments required include:

(A) \$3.00 per day for inpatient hospital services. Copayments for inpatient care paid under the Diagnosis Related Groups (DRG) methodology are calculated on the actual length of stay and are capped at \$90. Copayments for claims paid under Level of Care methodology are calculated at \$3.00 per day.

(B) \$3.00 per day for outpatient hospital services.

(C) \$3.00 per day for ambulatory surgery services including free-standing ambulatory surgery centers.

(D) \$1.00 for each service rendered by the following providers:

(i) Physicians,

(ii) Optometrists,

(iii) Home Health Agencies,

(iv) Rural Health Clinics,

(v) Certified Registered Nurse Anesthetists, and

(vi) Federally Qualified Health Centers.

(E) Prescription drugs.

(i) \$1.00 for prescriptions having a Medicaid allowable of \$29.99 or less.

(ii) \$2.00 for prescriptions having a Medicaid allowable of \$30.00 or more.

(F) Crossover claims. Dually eligible Medicare/Medicaid recipients must make a copayment of \$.50 per service for all Part B covered services. This does not include dually eligible HCBW service recipients.

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

The following are excluded from Medicaid coverage for adults:

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

(2) Services or any expense incurred for cosmetic surgery, including removal of benign skin lesions.

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

(4) Refractions and visual aids.

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

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

(7) Treatment for obesity.

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

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

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

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

(9) 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.

(10) Medical services considered to be experimental.

(11) Services of a Certified Surgical Assistant.

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

(13) Services of a Registered Physical Therapist.

(14) Services of a Psychologist.

(15) Services of a Speech and Hearing Therapist.

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

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

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

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 Authority'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 may be based on a determination made by the medical consultant in individual circumstances.

(1) Coverages include the following:

(A) Medically appropriate inpatient hospital visits are covered for all Medicaid 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 persons with proven malignancies or opportunistic infections.

(G) Direct physicians' services are covered on an outpatient basis. A maximum payment of four visits are covered per month per patient 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 physicians' services in a nursing facility for those patients approved for nursing care. Payment is made for a maximum of two nursing facility visits per month. To receive payment for a second nursing facility visit in a

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

(I) Payment is made for medically necessary diagnostic x-ray and laboratory work.

(J) One screening mammogram and one follow-up mammogram every year for women beginning at age 30. Additional follow-up mammograms are covered when medically necessary. A prior authorization by the Medical Professional Services Division of the Oklahoma Health Care Authority is required for additional follow-up mammograms. This includes interpretation and technical component.

(K) Obstetrical care.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure. Payment is made based upon an invoice for the item.

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

(N) If a physician personally sees a patient on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.

(O) Family planning - including sterilization procedures for legally competent persons 21 years of age and over who voluntarily request such a procedure and, with their physician, execute the Federally mandated consent form (ADM-71). A copy of the consent form must be attached to the claim form. Separate payment is made for an I.U.D. inserted 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 are not covered. Reversal of sterilization procedures may be covered when medically indicated and substantiating documentation is attached to the claim. The Norplant System for birth control is covered; however, removal of the Norplant System prior to five years is covered only when

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documented as medically necessary. Reinsertion of Norplant contraceptive will be considered on a case by case basis.

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

(Q) Blood count weekly for persons receiving the drug Clozaril.

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

(S) Payment of 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 patient 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 patients 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

Medicaid 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 patient must be at least minimally examined and reviewed by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) This 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) Organ and tissue transplantation services for children and adults, limited to bone marrow, stem cells, cornea, heart, kidney, liver, lung, SPK (simultaneous pancreas

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kidney), PAK (pancreas after kidney), and heart-lung, are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

(i) All transplantation services, 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 Medicaid program all organ transplants must be performed at a Medicare approved transplantation center.

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

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

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) Ambulatory services for treatment of persons 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 University of Oklahoma College of Pharmacy using form "Petition for TB Related Therapy". Ambulatory services to persons infected with TB are not limited to the scope of the Medicaid program, but require prior authorization when the scope is exceeded.

(2) General 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 including removal of benign skin lesions.

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

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

(D) Refractions and visual aids.

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

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

(G) Sterilization of persons who are under 21 years of age, mentally incompetent or institutionalized. 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 patient 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 patient including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.

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(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.

(Q) 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. (See OAC 317:30-5-6 or 317:30-5-50.)

(R) Night calls or unusual hours.

(S) Speech and Hearing services.

(T) Treatment for obesity, including weight reduction surgery.

(U) Mileage.

(V) Other than routine hospital visit on date of discharge unless patient expired.

(W) Direct payment to perfusionist as this is considered part of the hospital cost.

(X) Inpatient chemical dependency treatment.

(Y) Fertility treatment.

(Z) Routine immunizations.

(b) **Children.** Payment is made to physicians for medical and surgical services for persons 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 patients under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services will be prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services will not be Medicaid compensable.

(A) Effective October 1, 1993, all residential and acute psychiatric services will be authorized based on the medical necessity criteria as described in OAC 317:30-5-46.

(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 recipients in a particular border locality to use resources in another state. If a medical emergency occurs while a client is out of the state, treatment for medical services will be covered in the same way as they would be covered 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 persons 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.

(A) Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation which validates the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-46. Requests shall be made prior to the expiration of the approved inpatient stay.

(B) If a denial decision is made, a reconsideration request may be made directly to the OHCA, or its designated agent and should occur within 3 days of the denial notification due to the timeliness of processing such a request with the patient still in the facility. The request for reconsideration shall include new and/or additional medical information to justify the need for continued care.

(4) **Utilization control requirements for psychiatric beds.** Medicaid utilization control requirements for inpatient psychiatric services for persons 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 also made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of individuals under age 21. The EPSDT program is a comprehensive child health program, designed for ensuring the availability of and access to required health care resources and helping parents and guardians of Medicaid eligible children effectively use these resources. An effective EPSDT program assures that health problems found are diagnosed and treated early before they become more complex and their treatment more costly. The physician plays a significant role in educating parents and guardians in all services available through the EPSDT program. The receipt of an identified EPSDT screening makes the Medicaid child eligible for all necessary follow-up care that is within the scope of the Medicaid Program. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the Authority's current program. Such services must be allowable under the Federal Regulations. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and will require prior authorization. The following services are covered under EPSDT:

(A) The Oklahoma Program adopted the following recommendations which includes at least:

- (i) Six screenings during the first year of life;
 - (ii) Two screenings in the second year;
 - (iii) One screening yearly for ages two thru five years;
- and

(iv) One screening every other year for ages 6 thru 20 years.

(B) Periodicity schedules for screening, dental, vision and hearing, and other services include:

(i) **Screening services.** Comprehensive examinations performed by a licensed physician, dentist or other provider qualified under State law to furnish primary medical and health services are covered. See OAC 317:30-3-47 for EPSDT services. Screenings must include all of the following:

(I) A comprehensive health and developmental history (including assessment of both physical and mental health development);

(II) A comprehensive unclothed physical exam;

(III) Appropriate immunizations according to age and health history;

(IV) Laboratory tests (including lead blood level assessment appropriate to age and risk); and

(V) Health education (including anticipatory guidance).

(ii) **Vision services.** At a minimum, vision services include diagnosis and treatment for defects in vision, including eyeglasses. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal.

(iii) **Dental services.** At a minimum, dental services include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services. Coverage also includes inpatient services in an eligible participating hospital, outpatient dental screening every 12 months, two bite-wing x-rays, and/or oral prophylaxis one each 12 months; other restoration, repair and/or replacement of dental defects after the treatment plan submitted by a dentist has been authorized. This includes amalgam and composite restoration, pulpotomies, chrome steel crowns,

anterior root canals, pulpectomies, band and loop space maintainers, cement bases, acrylic flippers, and lingual arch bars. (Refer to Dental Provider Manual for limitations.)

(iv) **Hearing services.** At a minimum, hearing services include diagnosis and treatment for defects in hearing, including hearing aids. Hearing aid evaluation once every 12 months and purchase of a hearing aid when prescribed as a result of the hearing aid evaluation.

(v) **Immunizations.** Federal legislation created the Vaccine for Children Program to be effective October 1, 1994. Vaccines will be provided free of charge to all enrolled providers for Medicaid eligible children. Participating providers may bill for an administration fee to be set by HCFA on a regional basis. They may not refuse to immunize based on inability to pay the administration fee. Medicaid will continue to pay non-participating providers for vaccines and an administration fee of \$2.10 until April 1, 1995, when Federal Financial Participation will no longer be available.

(vi) **Appropriate laboratory tests.** Use medical judgement in determining the applicability of the laboratory tests or analyses to be performed. If any laboratory tests or analyses are medically contraindicated at the time of the screening, provide them when no longer medically contraindicated laboratory tests should only be given when medical judgement determines they are appropriate. However, laboratory tests should not be routinely administered.

(I) As appropriate, conduct the following laboratory tests: Anemia test; Sickle cell test. If a child has been properly tested once for sickle cell disease, the test need not be repeated. Tuberculin test. Give a tuberculin test to every child who has not received one within a year.

(II) Lead toxicity screening. Where age and risk factors indicate it is medically appropriate to perform a blood level assessment, a blood level assessment is mandatory. See OAC 317:30-3-50 for required lead screening guidelines.

(vii) **Other necessary health care.** Other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

(I) Interperiodic screenings outside the periodicity schedule for screening examinations are allowed at necessary intervals when a medical condition is suspected.

(II) Outpatient care for acute physical injury.

(III) Prescribed drugs beyond the prescription limitation.

(IV) Inpatient psychotherapy for individuals under 21 years of age when prior authorized. Payment is made to psychologists who are licensed to practice.

(V) Inpatient psychological testing. Limited to one hour per recipient each 12 months. If medically necessary, additional hours will be prior authorized. Payment is made to psychologists who are licensed to practice.

(VI) Outpatient psychological services for eligible individuals under 21 years of age when prior authorized. See (V) of this unit for limitations.

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

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

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

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

(G) Non-therapeutic hysterectomy.

(H) Medical Services considered to be experimental or

investigational.

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

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

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

(O) Treatment of obesity including weight reduction surgery.

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

(Q) Night calls or unusual hours.

(R) Mileage.

(S) Other than routine hospital visit on date of discharge unless patient expired.

(T) Tympanometry.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. For in-State physicians, claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare

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Benefits will reflect a message that the claim was referred to Medicaid. If such a message is not present, a claim for coinsurance and deductible must be filed with Medicaid 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 Medicaid 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 Medicaid must be filed within one year from the date of service. For dually eligible individuals, to be eligible for payment of coinsurance and/or deductible under Medicaid, a claim must be filed with Medicare within one year from the date of service.

317:30-5-9. Medical services

(a) **Use of medical modifiers.** The Physicians' Current Procedural Terminology (CPT) and the second level HCPCS provide for 2-digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

(1) Payment is made for four office visits (or home) per month per patient, for adults (over age 21), regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.

(2) Visits for the purpose of family planning are excluded from the four per month limitation.

(3) Payment is allowed for insertion of IUD in addition to the office visit.

(4) Separate payment will be made for the following supplies when furnished during a physician's office visit.

(A) Casting materials

(B) Dressing for burns

(C) Intrauterine device

(D) IV Fluids

(E) Medications administered by IV

(F) Glucose administered IV in connection with chemotherapy in office

(5) Payment is made for routine physical exams only as prior authorized by the County DHS office and are not counted as an office visit.

(6) Medically necessary office lab and X-rays are covered.

(7) Hearing exams by physician for persons between the ages of 21 and 65 are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.

(8) Hearing aid evaluations are covered for persons under 21 years of age.

(9) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.

(10) Payment is made for both office visit and injection of joints performed during the visit.

(11) Payment is made for an office visit in addition to allergy testing.

(12) Separate payment is made for antigen.

(13) Eye exams are covered for persons between ages 21 and 65 for medical diagnosis only.

(14) If a physician personally sees a patient on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.

(15) The following specimen collection fees are covered:

(A) Catheterization for collection of specimen, multiple patients.

(B) Catheterization for collection of specimen, single patient, all places of service.

(C) Routine Venipuncture.

(16) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.

(17) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.

(c) Non-covered office services.

(1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the

appropriate office visit code.

(2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.

(3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.

(4) Additional payment will not be made for night calls, unusual hours or mileage.

(5) Payment is not made for an office visit where the patient did not keep appointment.

(6) Refractive services are not covered for persons between the ages of 21 and 65.

(7) Removal of stitches is considered part of post-operative care.

(8) Payment is not made for a consultation in the office when the physician also bills for surgery.

(9) Separate payment is not made for oxygen administered during an office visit.

(d) Covered inpatient medical services.

(1) Payment is allowed for inpatient hospital visits for all Medicaid covered admissions. Psychiatric admissions must be prior authorized.

(2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient=s status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the patient's care, the codes for subsequent hospital care should be used.

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(3) Certain medical procedures are allowed in addition to office visits.

(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day and 4 units per month. Payment for critical care, each additional 30 minutes is limited to two units per day/month.

(e) Non-covered inpatient medical services.

(1) For inpatient services, all visits to a patient on a single day are considered one service except where specified. Payment is made for only one visit per day.

(2) A hospital admit or visit and surgery on the same day would not be covered if post-operative days are included in the surgical procedure. If there are no post-operative days, a physician can be paid for visits.

(3) Drugs administered to inpatients are included in the hospital payment.

(4) Payment will not be made to a physician for an admission or new patient work-up when patient receives surgery in out-patient surgery or ambulatory surgery center.

(5) Payment is not made to the attending physician for interpretation of tests on his own patient.

(f) Other medical services.

(1) Payment will be made to physicians providing Emergency Department services.

(2) Payment is made for two nursing home visits per month. The appropriate CPT code should be used.

(3) When payment is made for "Evaluation of arrhythmias" or "Evaluation of sinus node", the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.

(4) When the physician bills twice for the same procedure on the same day, it should be supported by a written report.

317:30-5-41. Coverage for adults

For persons 21 years of age or older, payment is made to hospitals for services as described in this Section.

(1) Inpatient hospital services.

(A) Effective August 1, 2000, all general inpatient hospital services for all persons 21 years of age or older is limited to 24 days per person per state fiscal year (July 1 through June 30). The 24 day limitation applies to both hospital and physician services. No exceptions or extensions will be made to the 24 day inpatient services limitation.

(B) Effective October 1, 2005, claims for inpatient admissions provided on or after October 1st in acute care hospitals will no longer be subject to the 24 days per person per fiscal year limit. Claims will be reimbursed utilizing a Diagnosis Related Groups (DRG) methodology.

(C) All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment.

(i) It is the policy and intent to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a Medicaid recipient. If the OHCA, or its designated agent, upon their initial review determines the admission should be denied, a notice is sent to the facility and the attending physician(s) advising them of the decision. This notice also advises that a reconsideration request may be submitted within 60 days. Additional information submitted with the reconsideration request will be reviewed by the OHCA, or its designated agent, who utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, OHCA is informed. At that point, OHCA sends a letter to the hospital and physician requesting refund of the Medicaid payment previously made on the denied admission.

(ii) If the hospital or attending physician did not request reconsideration by the OHCA, or its designated agent, the OHCA, or its designated agent, informs OHCA that there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, sends a letter to the hospital and physician requesting refund of the amount of Medicaid payment previously made on the denied admission.

(iii) If an OHCA, or its designated agent, review results in denial and the denial is upheld throughout the appeal process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services.

(D) If a hospital or physician believes that an acute care hospital admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient insists on treatment, the patient should be informed that he/she will be personally responsible for all charges. If a Medicaid claim is filed and paid and the service is later denied the patient is not responsible. If a Medicaid claim is not filed and paid the patient can be billed.

(E) Payment is made to a participating hospital for hospital based physician's services. The hospital must have a Hospital-Based Physician's Contract with OHCA for this method of billing.

(2) Outpatient hospital services.

(A) **Emergency hospital services.** Emergency department services are covered. Payment is made at a case rate which includes all non-physician services provided during the visit.

(B) **Level I - Complete Ultrasound.** Payment will be made separately from the total obstetrical care for one complete ultrasound per pregnancy when the patient has been referred to a radiologist or maternal fetal specialist trained in ultrasonography. The patient's record must be documented as to the reason the ultrasound was requested and the components of the ultrasound. The appropriate HCPC code must be used.

(C) **Level II - Targeted Ultrasound.** Payment will be made separately from the total obstetrical care for one medically necessary targeted ultrasound per pregnancy for high risk pregnancies. Documentation as to the medical justification must be made a part of the patient's record. The targeted ultrasound must be performed:

(i) with equipment capable of producing targeted quality evaluations; and

(ii) by an obstetrician certified by the American Board of Obstetrics and Gynecology as a diplomat with special qualifications in maternal fetal medicine or an active candidate for certification in maternal fetal medicine.

(iii) a complete ultrasound code is used if during the procedure it is apparent that a targeted ultrasound is not medically necessary.

(D) **Dialysis.** Payment for dialysis is made at the Medicare allowable facility rate. This rate includes all services which Medicare has established as an integral part of the dialysis procedure, such as routing medical supplies, certain laboratory procedures, oxygen, etc. Payment is made separately for injections of Epoetin Alfa (EPO or Epogen).

(E) **Technical component.** Payment is made for the technical component of outpatient radiation therapy and compensable x-ray procedures.

(F) **Laboratory.** Payment is made for medically necessary outpatient services.

(G) **Blood.** Payment is made for outpatient blood and blood fractions when these products are required for the treatment of a congenital or acquired disease of the blood.

(H) **Ambulance.**

(I) **Pharmacy.**

(J) **Home health care.** Hospital based home health providers must be Medicare certified and have a current Home Health Agency contract with the Oklahoma Health Care Authority.

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

(ii) Payment is made for a maximum of 36 visits per year per eligible recipient.

(iii) Payment is made for standard medical supplies.

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

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

(vi) Payment may be made at a statewide procedure based rate. Payment for any combination of skilled and home health aide visits shall not exceed 36 visits per year.

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

(I) Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. A completed HCFA-484 must accompany the initial claim for oxygen. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is considered most appropriate. Refer to the Medical Suppliers Manual for further information.

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

(III) Sterile tracheostomy trays are covered.

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

(V) Payment is made for hyperalimentation, including supplements, supplies and equipment rental in behalf of persons having permanently inoperative internal body

organ dysfunction. CC-17 should be submitted to the Medical Authorization Unit. Information regarding the patient's medical condition that necessitates the hyperalimentation and the expected length of treatment, should be attached.

(VI) Payment is made for ventilator equipment and supplies when prior authorized. CC-17 should be submitted to the Medical Authorization Unit.

(VII) Medical supplies, oxygen, and equipment should be billed using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.

(K) Outpatient hospital services, not specifically addressed.

Outpatient hospital services, not specifically addressed, are covered for adults only when prior authorized by the Medical Professional Services Unit of the Oklahoma Health Care Authority.

(L) Outpatient chemotherapy and radiation therapy. Payment is made for charges incurred for the administration of chemotherapy for the treatment of malignancies and opportunistic infections. Payment for radiation therapy is limited to the treatment of proven malignancies and benign conditions appropriate for stereotactic radiosurgery (e.g., gamma knife).

(M) Ambulatory surgery.

(i) **Definition of Ambulatory Surgical Center.** An ambulatory surgical center (ASC) is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients and which enters into an agreement with HCFA to do so. An ASC may be either independent (i.e., not part of a provider of services or any other facility) or may be operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). If an ASC is the latter type it has the option of being covered and certified under Medicare as an ASC, or of being covered as an outpatient hospital facility. In order to be covered as an ASC operated by a hospital, a facility must:

(I) elect to do so, and continue to be so covered unless HCFA determines there is good cause to do otherwise;

(II) be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital; and

(III) meet all the requirements with regard to health and safety, and agree to the assignment, coverage and reimbursement rules applied to independent ASC's.

(ii) **Certification.** In order to be eligible to enter into an agreement with HCFA to be covered as an ASC, a facility must be surveyed and certified as complying with the conditions for coverage for ASC's in 42 CFR 416.39-49.

(N) **Outpatient surgery services.** The covered facility services are defined as those services furnished by an ASC or OHF in connection with a covered surgical procedure.

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

(I) Nursing, technical and other related services. These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the facility. In addition to the nursing staff, this category would include orderlies and others involved in patient care.

(II) Use of the patient of the facility. This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.

(III) Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment. This category includes all supplies and equipment commonly furnished by the facility in connection with surgical procedures, including any drugs and biologicals administered while the patient is in the facility. Surgical dressings, other supplies, splints, and casts include those furnished by the facility at the time of surgery. Additional supplies and materials furnished

later would generally be furnished as incident to a physician's service and not as a facility service. Supplies include those required for both the patient and facility personnel, i.e., gowns, masks, drapes, hoses, scalpels, etc., whether disposable or reusable.

(IV) Diagnostic or therapeutic items and services directly related to the surgical procedure. Payment to the facility includes items and services furnished by facility staff in connection with covered surgical procedures. These diagnostic tests include but are not limited to tests such as urinalysis, blood hemoglobin or hematocrit, CBC and fasting blood sugar, etc.

(V) Administrative, recordkeeping, and housekeeping items and services. These include the general administrative functions necessary to run the facility, such as scheduling, cleaning, utilities, rent, etc.

(VI) Blood, blood plasma, platelets, etc. Under normal circumstances, blood and blood products furnished during the course of the procedure will be included in the payment for the facility charge. In cases of patients with congenital or acquired blood disorders, additional payment can be made within the scope of the Authority's Medical Programs.

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

(ii) **Services not included in facility reimbursement rates.** The following services are not included in the facility reimbursement rate:

(I) Physicians' services. This category includes most services performed in the facility which are not considered facility services. The term physicians' services includes any pre/postoperative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, or other services which the individual physician usually includes in a set "global" fee for a given surgical procedure.

(II) The sale, lease, or rental of durable medical equipment to facility patients for use in their homes.

If the facility furnishes items of DME to patients it should be treated as a DME supplier and these services billed on a separate claim form. Coverage of DME is limited to the scope of the Authority's Medical Programs.

(III) Prosthetic devices. Prosthetic devices, whether implanted, inserted, or otherwise applied by covered surgical procedures are not included in the facility payment. One of the more common prosthesis is intra-ocular lenses (IOL's). Prosthetic devices should be billed as a separate line item using appropriate HCPCS code.

(IV) Ambulance services. If the facility furnishes ambulance services, they are covered separately as ambulance services if otherwise compensable under the Authority's Medical Programs.

(V) Leg, arm, back and neck braces. These items are not included in the facility payment. Payment is limited to the scope of the Authority's Medical Programs.

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

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

(iii) **Reimbursement - facility services.** The facility services are reimbursed according to the group in which the surgical procedure is listed. If more than one surgical procedure is performed at the same setting, reimbursement will be made for only the major procedure. Reimbursement will be made at a state-wide payment rate based on Medicare's established groups.

(iv) **Compensable procedures.** The HCPCS codes identify the

compensable procedures and should be used in billing.

(O) **Outpatient hospital services for persons infected with tuberculosis (TB).** Outpatient hospital services are covered for persons infected with tuberculosis. Coverage includes, but may not be limited to, outpatient hospital visits, laboratory work and x-rays. Services to persons infected with TB are not limited to the scope of the Medicaid program; however, prior authorization is required for services that exceed the scope of coverage under Medicaid. Drugs prescribed for the treatment of TB not listed in OAC 317:30-3-46 require prior authorization by the University of Oklahoma College of Pharmacy using form "Petition for TB Related Therapy".

(P) **Mammograms.** Medicaid covers one screening mammogram and one follow-up mammogram every year for women beginning at age 30. Additional follow-up mammograms are covered when medically necessary. A prior authorization by the Medical Professional Services Division of the Oklahoma Health Care Authority is required for additional follow-up mammograms.

(Q) **Treatment/Observation.** Payment is made for the use of a treatment room, or for the room charge associated with outpatient observation services. Observation services must be ordered by a physician or other individual authorized by state law. Observation services are furnished by the hospital on the hospital's premises and include use of the bed and periodic monitoring by hospital staff. Payment is not made for treatment/observation on the same day as an emergency room visit. Observation services are limited to one 24 hour period per incident. Observation services are not covered in addition to an outpatient surgery.

(R) **Clinic charges.** Payment is made for a facility charge for services provided in non-emergency clinics operated by a hospital. This payment does not include the professional charges of the treating physician, nurse practitioner, physician assistant or charges for diagnostic testing. A facility charge is also allowed when drug and/or blood are administered outpatient.

(3) **Exclusions.** The following are excluded from coverage:

(A) Inpatient diagnostic studies that could be performed on

an outpatient basis.

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

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

(D) Medical services considered to be experimental.

(E) Services or any expense incurred for cosmetic surgery including removal of benign skin lesions.

(F) Refractions and visual aids.

(G) Payment for the treatment of obesity.

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

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

Reimbursement will be made for inpatient hospital services rendered on or after October 1, 2005, in the following manner:

(1) Covered inpatient services (including organ transplants) provided to eligible Medicaid recipients admitted to in-state acute care and critical access hospitals will be reimbursed at a prospectively set rate which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. For each Medicaid recipient's stay, a peer group base rate is multiplied by the relative weighting factor for the DRG which applies to the hospital stay.

In addition to the Drug payment, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if the DRG payment is less than \$50,000 of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to 70% of the cost after the \$50,000 threshold is met.

(2) The DRG payment and outlier, if applicable, represent full reimbursement for all non-physician services provided the inpatient. Payment includes but is not limited to:

(A) laboratory services;

(B) prosthetic devices, including pacemakers, lenses, artificial joints, Cochlear implants, implantable pumps;

(C) technical component on radiology services; and

(D) transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible recipients of the Oklahoma Medicaid program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals.

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(5) Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

(6) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

(7) Readmissions occurring within 15 days of prior acute care admission for a related condition will be reviewed under a retrospective utilization review policy to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the OHCA.

(8) Hospital stays less than three days in length will be reviewed under a retrospective utilization review policy for medical necessity and appropriateness of care. (Discharges involving healthy mother and healthy newborns may be excluded from this review requirement.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient stay will be denied.

(9) Organ transplants must be performed at an institution approved by the OHCA for the type of transplant provided. The transplant must be reviewed for medical appropriateness.

(10) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by Medicaid recipients and the provider will not accept the DRG payment rate. Prior authorization is required.

(11) New providers entering the Medicaid program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

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

(a) Eligibility. A hospital shall be deemed a disproportionate share hospital, as defined by Section 1923 of the federal Social Security Act, if the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or if the hospital's low-income utilization rate exceeds 25%.

(1) Eligibility for disproportionate share hospital payments will be determined annually by the OHCA before the beginning of each federal fiscal year based on cost and revenue survey data completed by the hospitals. The survey must be received by OHCA each year by April 30. The information used to complete the survey must be extracted from the hospital's financial records and fiscal year cost report ending in the most recently completed calendar year, for entities that meet the Medicare Provider designation (refer to Medicare Program Memorandum No. A-96-7 for requirements). A hospital may not include costs or revenues on the survey which are attributable to services rendered in a separately licensed/certified entity. Hospitals found to be ineligible for disproportionate share status upon audit shall be required to reimburse the Authority for any disproportionate share payment adjustments paid for the period of ineligibility.

(2) Beyond meeting either of the tests found in (1) of this subsection, there are three additional requirements which are:

(A) Any hospital offering non-emergency obstetrical services must have at least two obstetricians with staff privileges who have agreed to provide services to Medicaid beneficiaries. This requirement does not apply to children's hospitals.

(B) In the case of an urban hospital, a hospital located in a MSA, an "obstetrician" is defined as any board-certified obstetrician with staff privileges who performs non-emergency obstetrical services at the hospital. In the case of a rural hospital, an "obstetrician" is defined to include any physician with staff privileges who performs non-emergency obstetrical services at the hospital.

(C) A hospital must have a Medicaid inpatient utilization

rate of at least one percent.

(b) Payment adjustment.

(1) Beginning federal fiscal year 1993 and each year thereafter, DSH payment adjustments will be capped by the federal government. Financial participation from the federal government will not be allowed for expenditures exceeding the capped amount. Eligible DSH hospitals will be assigned to one of the three following categories:

(A) public-private acute care teaching hospital which has 150 or more full-time equivalent residents enrolled in approved teaching programs (using the most recently completed annual cost report) and is licensed in the state of Oklahoma. Public-private hospital is a former state operated hospital that has entered into a joint operating agreement with a private hospital system;

(B) other state hospitals; or

(C) private hospitals and all out-of-state hospitals.

(2) Payment adjustments will be made on a quarterly basis for federal fiscal year 1994 and thereafter using the following formula that determines the hospital's annual allocation:

(A) Step 1. The Medicaid revenue and imputed revenue for charity are totaled for each hospital qualifying for disproportionate share adjustments.

(B) Step 2. A weight is assigned to each qualifying hospital by dividing each hospital's revenue total (Medicaid and charity) by the revenue total of the public-private acute care teaching hospital, which has the assigned weight of 1.0.

(C) Step 3. A weighted value is then determined for each hospital by multiplying the hospital's assigned weight by the hospital's total Medicaid and charity revenue.

(D) Step 4. The weighted values of all hospitals qualifying for disproportionate share adjustments are totaled.

(E) Step 5. The percentage of the public-private acute care teaching hospital's weighted value is determined in relation

to the weighted values of all qualifying disproportionate share hospitals.

(F) Step 6. The weighted values of all state hospitals (except public-private acute care teaching hospital) are totaled.

(G) Step 7. The weighted values of all private and out-of-state hospitals qualifying for disproportionate share adjustments are totaled.

(H) Step 8. The percentage of the total weighted values of the hospitals included in Step 6 (State hospitals except public-private acute care teaching hospital) is calculated in relation to the total weighted values (sum of Step 6 and 7) of all remaining hospitals qualifying for disproportionate share adjustment.

(I) Step 9. The percentage of weighted values of the hospitals included in Step 7 (private hospitals and all out-of-state hospitals) is calculated in relation to the total weighted values (sum of Steps 6 and 7) of all remaining hospitals qualifying for disproportionate share adjustment.

(J) Step 10. The weighted percentages for the three hospital groups are next applied to the capped disproportionate share amount allowed by CMS for the federal fiscal year. The amount of disproportionate share to be paid to the public-private acute care teaching hospital is determined by multiplying the state disproportionate share allotment by the weighted percentage of the public-private acute care teaching hospital. Beginning FFY 96, the weighted percentage amount to be paid will not exceed 82.82%. Payment of disproportionate share funds to public/private hospitals will be made to the public entity that is organizationally responsible for indigent care. The weighted percentage amount is then subtracted from the state disproportionate share allotment. Once the public-private acute care teaching hospital's share of the state disproportionate share allotment has been subtracted, the state hospitals' weighted percentage is applied to the remainder. Beginning FFY 96, the State hospital's weighted percentage [from (H) of this paragraph] will not be less than 75.3%. The balance of the disproportionate share allotment is distributed to private hospitals and all out-of-state hospitals. Distribution of

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funds within each group will be made according to the relationship of each hospital's weighted value to the total weighted value of the group.

(3) Payment adjustments to individual hospitals will be limited to 100 percent of the hospital's costs of providing services (inpatient and outpatient) to Medicaid recipients and the uninsured, net of payments received from Medicaid (other than DSH) and uninsured patients.

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

(a) Effective February 11, 1999, acute care hospitals that qualify as major teaching hospitals will receive an indirect medical education (IME) payment adjustment, which covers the increased operating, or patient care, costs that are associated with approved intern and resident programs.

(b) In order to qualify as a major teaching hospital and be deemed eligible for an IME adjustment, the hospital or hospitals of common ownership must:

(1) belong to the Council on Teaching Hospitals or have a medical school affiliation; and

(2) be licensed by the State of Oklahoma; and

(3) have 150 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

(c) Eligibility for an IME adjustment will be determined by the OHCA, using the provider's most recently received annual cost report or the application (see OAC 317:30-5-47.3) for the quarterly Direct Medical Education Supplemental payment adjustment.

(d) An annual fixed IME payment pool will be established based on the State matching funds made available by transfers from other State agencies. The pool of funds will be distributed annually each State fiscal year. The total pool of monies made available by funds transferred by any State agency will be limited to \$10,038,714, the 1999 base year amount. The base year payment amount will be updated annually each July 1 using the first quarter publication of the DRI PPS-type Hospital market basket forecast for the midpoint of the upcoming fiscal year, if funds are available.

(e) The payments will be distributed equally. For hospitals that have public-private ownership, or have entered into a joint operating agreement, payment will be made to the public entity that is organizationally responsible for the public teaching mission.

(f) If payment causes total payments to exceed Medicare upper limits as required by 42 CFR 447.272, the payment will be reduced to not exceed the Medicare upper limit.

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

OAC 317:30-5-47.4 (p1)

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

(a) Effective July 1, 1999, in-state hospitals that qualify as teaching hospitals will receive a supplemental payment adjustment for direct medical education (DME) expenses. These payments will be made in order to encourage training in rural hospital and primary care settings and to recognize the loss of support for GME due to the advent of Managed Care capitated programs.

(b) In order to qualify as a teaching hospital and be deemed eligible for DME supplemental incentive payment adjustments, the hospital must:

(1) be licensed by the State of Oklahoma;

(2) have costs associated with approved or certified Oklahoma medical residency programs in medicine, osteopathic medicine, and associated specialties and sub-specialties. An approved medical residency program is one approved by the Accrediting Council for Graduate Medical Education of the American Medical Association, by the Bureau of Professional Education of the American Osteopathic Association, or other professional accrediting associations. A resident is defined as a Post-Graduate Year 1 (PGY1) and above resident who participates through hospital or hospital-based rotations in approved medical residency/internship programs in Family Medicine, Internal Medicine, Pediatrics, Surgery, Ophthalmology, Psychiatry, Obstetrics/Gynecology, Anesthesiology, Osteopathic medicine, or other Certified Medical Residencies, including specialties and sub-specialties as required in order to become certified by the appropriate board; and

(3) apply for certification by the OHCA prior to receiving payments for any quarter during a State Fiscal year. To qualify, a hospital must have a contract with the Oklahoma Health Care Authority (OHCA) to provide Medicaid services and belong to The Council on Teaching Hospitals or otherwise show proof of affiliation with an approved Medical Education Program.

Affiliation means an agreement to support the costs of medical residency education in the approved programs.

(4) Federal and state hospitals, including Veteran's Administration, Indian Health Service/Tribal and Oklahoma Department of Mental Health and Substance Abuse Services

**MEDICAL PROVIDERS-FEE FOR SERVICE
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OAC 317:30-5-47.4 (p2)

Hospitals are not eligible for supplemental DME payments. Major teaching hospitals are eligible.

(c) Determination of a hospital's eligibility for a DME supplemental payment adjustment will be done quarterly by the OHCA based on reports designed by the OHCA. The reports will detail the resident-months of support provided by the hospital and the total eligible Medicaid days of service from the paid claims for the same quarter and be attested to by the hospital Administrator, or designated personnel. The annual application must be attested to by the hospital administrator and by the residency program director. All reports will be subject to audit and payments will be recouped for inaccurate or false data. The amount of resident-months will also be compared to the annual budgets of the schools, the annual CMS form 2552 (Cost Report) and the monthly assignment schedules.

(d) An annual fixed DME payment pool will be established based on the State Matching funds made available by the University Hospitals Authority or other State agencies.

(e) The payments will be distributed based on the relative value of the weighted resident-months at each participating hospital. A resident-month is defined as a PGY1 and above resident full-time equivalent (FTE) for that month. Resident is defined in (b)(2) of this section. An FTE is defined as a resident assigned by the residency program to a rotation that is hospital or hospital-based. The resident must be assigned to a specific hospital for a supervised hospital-based residency experience. Required residency clinical or educational experience will be allowed. The time residents spend in non-provider settings such as freestanding clinics, nursing homes and physicians' offices in connection with approved programs may be included in determining the number of FTE=s in the count if the following conditions are met:

(1) The resident spends his or her time in patient care activities.

(2) The written agreement between the hospital and the non-hospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the non-hospital site and the hospital is providing reasonable compensation to the non-hospital site for supervisory teaching activities.

**MEDICAL PROVIDERS-FEE FOR SERVICE
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OAC 317:30-5-47.4 (p3)

(3) The hospital must incur all or substantially all of the costs for the training program in the non-hospital setting, which means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.

(f) Training outside the formal residency program (moonlighting) is not eligible for this payment. The pool of available funds will be distributed quarterly based on the relative value of the eligible hospitals' resident-months weighted for Medicaid services rendered.

(1) The weighted relative value is determined as follows:

(A) Annually (prior to each state fiscal year) the OHCA will determine each participating hospital's individual acuity factor from data taken from the Oklahoma MMIS system (or reported claims data) by using the days of services and weights determined for the levels of care.

(B) Determine the total resident-months from the quarterly reports in (c) of this section for each hospital.

(C) Determine the total eligible patient days for the quarter from the quarterly reports in (c) of this section for each hospital reporting.

(D) Determine the relative value for each hospital. The relative value is defined as the product of the individual acuity factor [see (A) of this paragraph] times the total resident-months [see (B) of this paragraph] times the eligible patient days [see (C) of this paragraph].

(2) The pool of available funds will be allocated quarterly based on the prior quarter's relative value as determined in (1)(D) of this subsection. The per resident-month amount will be limited to \$11,000 and the total payments will be limited to and not exceed the upper payment limits described in (g) of this section.

(g) If payment in (d) of this section causes total payments to exceed Medicare upper limits as required by CFR 447.272, the payment will be reduced to not exceed the Medicare upper limit.

317:30-5-47.5. Critical Access Hospitals

Critical Access Hospitals (CAHs) are rural public or non-profit hospitals which have been certified by Medicare as a Critical Access Hospital. The facility must provide documentation to be determined eligible for the CAH peer group.

317:30-5-110. Eligible providers

To be eligible for reimbursement, all licensed rehabilitation hospitals must be Medicare certified and have a current contract on file with the Oklahoma Health Care Authority (OHCA).

317:30-5-111. Coverage for adults

For persons 21 years of age or older, payment is made to hospitals for inpatient services as described in this section.

(1) All general inpatient hospital services which are not provided under the Diagnosis Related Group (DRG) payment methodology for all persons 21 years of age or older is limited to 24 days per person per state fiscal year (July 1 through June 30). The 24 day limitation applies to both hospital and physician services. No exceptions or extensions will be made to the 24 day inpatient services limitation.

(2) All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment.

(A) It is the policy and intent to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a Medicaid recipient. If the OHCA, or its designated agent, upon their initial review determines the admission should be denied, a notice is sent to the facility and the attending physician(s) advising them of the decision. This notice also advises that a reconsideration request may be submitted within 60 days. Additional information submitted with the reconsideration request will be reviewed by the OHCA, or its designated agent, who utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, OHCA is informed. At that point, OHCA sends a letter to the hospital and physician requesting refund of the Medicaid payment previously made on the denied admission.

(B) If the hospital or attending physician did not request reconsideration by the OHCA, or its designated agent, the OHCA, or its designated agent, informs OHCA that there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, sends a letter to the hospital and physician requesting refund of the amount of Medicaid payment previously made on the denied admission.

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

OAC 317:30-5-111 (p2)

(C) If an OHCA, or its designated agent, review results in denial and the denial is upheld throughout the appeal process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services.

(3) If a hospital or physician believes that a hospital admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient insists on treatment, the patient should be informed that he/she will be personally responsible for all charges. If a Medicaid claim is filed and paid and the service is later denied, the patient is not responsible. If a Medicaid claim is not filed and paid, the patient can be billed.

(4) Payment is made to a participating hospital for hospital based physician's services. The hospital must have a Hospital-Based Physician's contract with OHCA for this method of billing.

317:30-5-112. Coverage for children

Payment is made to rehabilitation hospitals for medical services for persons under the age of 21 within the scope of the Authority's Medical Programs, provided the services are reasonable for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services are comparable to those listed for adults except all medically necessary inpatient hospital services, other than psychiatric services, for all persons under the age of 21 will not be limited.

317:30-5-113. Medicare eligible individuals

Payment is made to hospitals for services to Medicare eligible individuals as set forth in this section.

(1) Individuals eligible for Part A and Part B.

(A) Payment is made utilizing the Medicaid allowable for comparable Part B services.

(B) Payment is made for the coinsurance and/or deductible for Part A services for categorically needy individuals.

(2) Individuals who are not eligible for Part A services.

(A) The Part B services are to be filed with Medicare. Any monies received from Medicare and any coinsurance and/or deductible monies received from OHCA must be shown as a third party resource on the appropriate claim form for inpatient per diem. The inpatient per diem should be filed with the fiscal agent along with a copy of the Medicare Payment Report.

(B) For individuals who have exhausted Medicare Part A benefits, claims must be accompanied by a statement from the Medicare Part A intermediary showing the date benefits were exhausted.

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

OAC 317:30-5-114

317:30-5-114. Reimbursement

Payment is made at the lesser of the facilities usual and customary fee or the OHCA fixed per diem rate.

317:30-5-122. Levels of care

The level of care provided by a long term care facility to a patient is based on the nature of the health problem requiring care and the degree of involvement in nursing services/care needed from personnel qualified to give this care.

(1) **Skilled Nursing facility.** Payment is made for the Part A coinsurance for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.

(2) **Nursing Facility.** Care provided by a nursing facility to patients who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical conditions or a combination of physical and mental conditions.

(3) **Intermediate Care Facility for the Mentally Retarded.** Care provided by a nursing facility to patients who require care and active treatment due to mental retardation or developmental disability combined with one or more handicaps. The mental retardation or developmental disability must have originated during the patient's developmental years (prior to 22 years of chronological age).

317:30-5-225. Eligible providers

The Nurse-Midwife must be a qualified professional nurse registered with the Oklahoma Board of Nurse Registration and Nursing Education who possesses evidence of certification according to the requirement of the American College of Nurse-Midwives, and has the right to use the title Certified Nurse-Midwife and the abbreviation C.N.M. Nurse Midwives 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.

(1) In accordance with the Omnibus Budget Reconciliation Act of 1993, effective October 1, 1993, certified nurse midwife services include maternity services, as well as services outside the maternity cycle within the scope of their practice under state law.

(2) The signature of the Nurse-Midwife on Form MS-MA-5, Notification of Needed Medical Services, will be acceptable as medical verification of pregnancy. Form MS-MA-5 should be filed after the first prenatal visit with the local county Oklahoma Department of Human Services office in the county where the patient resides. If Form MS-MA-5 is not completed, a written statement from the Nurse-Midwife verifying the applicant is pregnant and the expected date of delivery is acceptable.

317:30-5-335. Eligible providers

To be eligible for reimbursement, an ambulance company or a stretcher service must be licensed by the State Department of Health. Ambulance companies and all other transportation providers must have a current contract on file with the Oklahoma Health Care Authority (OHCA).

317:30-5-336. Coverage for adults

Ambulance transportation for adults is covered as set forth in this Section

(1) Covered services.

(A) Ambulance and stretcher transportation is covered only when medically necessary and when due to the patient's condition any other method of transportation is contraindicated. Stretcher service is limited to those situations within the scope of the license extended to the entity. The OHCA's Non-Emergency Transportation (NET) Waiver, known as SoonerRide, is the first choice for non-emergency transportation for scheduled medical services. SoonerRide provides non-emergency transportation in accordance with all applicable criteria set forth in the American's with Disabilities Act (ADA). Regularly scheduled non-emergency medical services, such as outpatient dialysis, must be scheduled through SoonerRide unless the patient's condition requires transportation by stretcher or ambulance. All claims for scheduled trips for outpatient services which cannot be provided by SoonerRide must be accompanied by medical documentation to substantiate the need for the higher level of transportation and will be reviewed prior to payment by OHCA staff. Ambulance or stretcher transport for unscheduled emergent medical care will be covered if the trip meets all applicable criteria.

(B) As a general rule, only ambulance or stretcher transportation within the ambulance locality is covered. Ambulance locality means the service area surrounding the facility from which individuals normally travel or are expected to travel to seek medical care. OHCA utilizes the locality areas as defined by Medicare. If ambulance transportation is provided out of the ambulance locality, the claim must be documented with the reason for the trip outside of the service area. If it is determined the patient was transported out of locality and the closest facility could have cared for the patient, payment will be made only for the distance to the nearest medical institution with appropriate facilities.

(C) Appropriate facilities means that the institution is generally equipped to provide the needed hospital or skilled

nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or physician specialist is available to provide the necessary care required to treat the patient's condition. However, the fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities.

Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

(D) The fact that a more distant institution is better equipped to care for the patient does not mean that a closer institution does not have "appropriate facilities". Such a finding is warranted, however, if the beneficiary's condition requires a higher level of trauma care or other specialized service available only at the more distant hospital. However, a legal impediment barring a patient's admission would mean that the institution did not have "appropriate facilities". For example, the nearest transplant center may be in another state and that state's law precludes admission of nonresidents.

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

(F) Transportation to the outpatient facilities of a hospital, free-standing Ambulatory Surgery Center, Independent Diagnostic Testing Facility (IDTF), physician's office, or other outpatient facility is compensable if the patient's condition necessitates ambulance transportation. See definition of bed confined in (P) of this paragraph.

(G) If a beneficiary is transported to a destination and returned to their original point of pickup, coverage will include payment for the primary transport and return transport. If the provider is required to remain and attend the patient between transports, the provider may claim waiting time. Waiting time shall be paid in half hour increments and shall not include the first half hour. The first 30 minutes of waiting time is included in the base rates.

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

OAC 317:30-5-336 (p3)

(H) Ambulance transportation from a hospital with a higher level of care to a hospital in the locality is covered.

(I) Transportation from a hospital to a hospital with a lower level of care is covered only if the patient is expected to be inpatient for a period greater than one week and the transfer will afford the patient greater access to family and/or caregivers.

(J) Ambulance transportation from nursing home to nursing home (skilled or intermediate care) is covered only if the discharging institution is not certified and the admitting nursing home is certified. Nursing home to nursing home transfers are also covered if the patient requires care not available at the discharging facility, i.e., secure Alzheimer's Unit, and the patient's medical status requires ambulance transport.

(K) Transportation for residents of nursing facilities to hospital and back home on same day is covered if medical necessity is documented.

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

(M) If the patient refuses treatment after immediate aid has been provided, the ambulance may bill for waiting time and the base rate.

(N) When twins are transported, payment is made for only one trip as twins are considered as one passenger.

(O) Payment is made according to the medically necessary services actually furnished. That is, payment is based on the level of service furnished, not simply on the vehicle used.

(P) Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. Non-emergency transports are not covered unless the patient is bed confined or has a medical condition that requires medical expertise not available with a less specialized method of transportation.

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

OAC 317:30-5-336 (p4)

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

(Q) If the patient dies before dispatch, no payment is available. If the patient dies after dispatch, but before the patient is loaded, payment is allowed for the base rate but no mileage. If the patient dies after pickup, payment is available for the base rate and mileage. Time of death is the point at which the patient is pronounced dead by an individual authorized by the State to make such pronouncements.

(R) Air Ambulance Services, which includes fixed and rotary wing transportation, are covered only where:

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

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

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

(iv) Base rate includes the lift off, professional intensive care, transport isolette, ventilator setup, respiratory setup, and all other medical services provided during the flight.

(v) If the accident scene is inaccessible by air and a land ambulance must pick up the patient to transport to a site where the air ambulance can land, the land ambulance trip is covered.

(vi) Air transportation is covered only to a hospital.

(vii) If the patient dies before takeoff, no payment is made. This includes situations in which the air ambulance has taxied to the runway, has been cleared for takeoff, but has not actually taken off. Failure of the dispatcher to notify the pilot of the death does not negate this rule. If the patient dies after takeoff but before the patient is loaded, payment is made for the base rate but no mileage. If the patient dies after the patient is loaded, payment is made for the base rate and mileage. Time of death is defined as the point at which the patient has been pronounced dead by an individual authorized by the State to make such pronouncements.

(viii) Only one base rate is allowed per trip.

(2) Non-covered services.

(A) Transportation by ambulance when patient's condition did not require that level of transportation and another mode of transportation would suffice.

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

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

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

(E) Ambulance transportation is not covered when provided while the patient was an inpatient. For example, transportation to and from another facility for tests, x-rays, etc., while still an inpatient of another facility is not compensable. All non-physician services furnished an inpatient are part of the inpatient bill.

(F) Payment is not made for more than one base rate per trip.

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

OAC 317:30-5-343

317:30-5-343. Reimbursement

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

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 subchapter 15,485; 10-15-1 thru 485 10-16-9 of Oklahoma Nursing Practice Act. 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.