
POLICY TRANSMITTAL NO. 09-60	DATE: DECEMBER 11, 2009
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS AND POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-3-24; 30-3-59 through 30-3-60; 30-5-2; 30-5-9; 30-5-20;
30-5-42.17; 30-5-65; 30-5-72.1; 30-5-211.10; 30-5-211.17; 30-5-241.3;
and 35-13-4.

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

Rules are revised to provide clarification and consistency with practices for coverage for certain nutritional formulas and bars for children diagnosed with certain metabolic disorders. Currently rules only indicate nutritional formula and bars are covered for persons diagnosed with PKU. OHCA practice is that certain nutritional formulas and bars are covered with the diagnosis of certain metabolic disorders and prior authorization.

The rule revision provides clarification of member responsibilities regarding the reporting of third party liability, utilization of private insurance and notification to medical providers of SoonerCare coverage. The rule provides that SoonerCare members with additional insurance are required to inform medical providers of their coverage from all sources. The rule also clarifies that SoonerCare members having private insurance must comply with all requirements of the private carrier before seeking coverage through SoonerCare. Lastly the rule clarifies that individuals applying for SoonerCare services must notify their providers of the intent to apply and of any retroactive eligibility determinations.

This rule revises policy to include language ensuring SoonerCare members agree to allow sharing of medical information, if needed, to state and federal agencies, medical providers and OHCA designees, upon their acceptance of SoonerCare services. Prior to this rule change medical information could only be released to other agencies to whom the member had applied for services. The current scope of information sharing creates limitations on the ability of the OHCA to properly review, monitor or obtain payment for services rendered. The revised rule will allow for a more comprehensive and efficient provision of services, as well as an

increase in the ability of the OHCA to determine proper liability for payment of those services.

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's general coverage guidelines. Rules are revised to clarify the intent of covered and non-covered benefits and provide consistency throughout policy. These emergency rule revisions will make rules consistent with reimbursement practices and clarify coverage and access to healthcare for Oklahomans, thereby reducing confusion among SoonerCare providers regarding general coverage and general coverage exclusions and ultimately reducing the amount of uncompensated care provided by healthcare providers.

Agency rules are revised to make DME rules consistent with reimbursement practices and provide consistency throughout policy. Revisions include clarifying the intent of wheelchair coverage for members residing in a long term care facility or ICF/MR and the elimination of the OHCA Certificate of Medical Necessity (CMN) as a document requirement for requesting prior authorization or determining medical necessity for wheelchairs.

Rules are being revised to allow family inclusion during Behavioral Health Rehabilitation Services. This revision will provide consistency between OHCA policy and practices.

Original signed on 12-9-09

Mary Stalnaker, Director
Family Support Services Division

Sandra Harrison, Coordinator
Office of Legislative Relations and Policy

WF # 09-CC (NAP)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

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

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, OKDHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, OKDHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at 405-521-4326.

<u>REMOVE</u>	<u>INSERT</u>
317:30-3-24	317:30-3-24, pages 1-2, revised 11-3-09
317:30-3-59	317:30-3-59, pages 1-2, revised 11-3-09
317:30-3-60	317:30-3-60, pages 1-2, revised 11-3-09
317:30-5-2	317:30-5-2, pages 1-9, revised 11-3-09
317:30-5-9	317:30-5-9, pages 1-3, revised 11-3-09
317:30-5-20	317:30-5-20, pages 1-2, revised 11-3-09
317:30-5-42.17	317:30-5-42.17, 1 page only, revised 11-3-09
317:30-5-65	317:30-5-65, 1 page only, revised 1-1-10
317:30-5-72.1	317:30-5-72.1, pages 1-2, revised 11-3-09
317:30-5-211.10	317:30-5-211.10, 1 page only, revised 1-1-10
317:30-5-211.17	317:30-5-211.17, pages 1-3, revised 1-1-10
317:30-5-241.3	317:30-5-241.3, pages 1-2, revised 11-3-09
317:35-13-4	317:35-13-4, 1 page only, revised 11-3-09

317:30-3-24. Third party liability

As the Medicaid Agency, OHCA is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. Guidance for third party liability under the Insure Oklahoma program is found in OAC 317:45, Oklahoma Employer and Employee Partnership for Insurance Coverage.

(1) If a member has coverage by an absent parent's insurance program or any other policy holder, that insurance resource must be used prior to filing a SoonerCare claim. This includes Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and any other insuring arrangements that provide a member access to healthcare. Members must comply with all requirements of their primary insurance as well as SoonerCare requirements in order to take advantage of both coverages. For example, a member must comply with the network restrictions of both the primary and SoonerCare plans as well as prior authorization requirements. If the member does not comply with the requirements of the primary plan, he/she will be responsible for the charges incurred. Denials by private insurance companies because the member did not secure a preauthorization or use a participating provider is not a sufficient reason for SoonerCare to make payment. If the provider is aware of private insurance or liability, a claim must first be filed with that source. When private insurance information is known to the OHCA, the eligibility verification system will reflect that information. If payment is denied by the primary insurance, except as stated above, the provider must attach the Explanation of Benefits (EOB), stating the reason for the denial, to the claim submitted to the Fiscal Agent. When payment is received from another source, that payment amount must be reflected on the claim form.

(2) It is possible that other resources are available but are unknown to OHCA. Providers will routinely question SoonerCare members to determine whether any other resources are available.

In some instances, coverage may not be obvious, for example, the member may be covered by a policy on which he/she is not the subscriber (e.g., a child whose absent parent maintains medical and hospital coverage).

(3) If the provider receives payment from another source after OHCA has made payment, it is necessary that the provider reimburse OHCA for the Title XIX (Medicaid) payment. The provider may retain the primary insurance payment, if any, that represents payment for services that are not covered services

under SoonerCare. By accepting the OHCA=s payment, the provider agrees to accept it as payment in full and, therefore, cannot retain any portion of other resource money as payment for reduced charges on covered services. Other than SoonerCare copayments, a provider cannot bill a member for any unpaid portion of the bill or for a claim that is not paid because of provider administrative error. If, after reimbursing OHCA and retaining a portion of the other payment in satisfaction of any non-covered services there is money remaining, it must be refunded to the member.

(4) If a member is covered by a private health insurance policy or plan, he/she is required to inform medical providers of the coverage, including:

(A) provision of applicable policy numbers;

(B) assignment payments to medical providers;

(C) provision of information to OHCA of any coverage changes; and

(D) release of money received from a health insurance plan to the provider if the provider has not already received payment or to the OHCA if the provider has already been paid by the OHCA.

(5) Members are responsible for notifying their providers of the intent to make application for SoonerCare coverage and of any retroactive eligibility determinations. Members may be responsible for any financial liability if they fail to notify the provider of the eligibility determinations and as a result, the provider is unable to secure payment from OHCA.

(6) Members must present evidence of SoonerCare and any other health insurance coverage to a medical provider each time services are requested. Members may be responsible for any financial liability if they fail to furnish the necessary information before the receipt of services and as a result, the provider is unable to secure payment from OHCA.

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

The following are excluded from SoonerCare coverage for adults:

- (1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
- (2) Services or any expense incurred for cosmetic surgery.
- (3) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member=s care, the procedure codes for subsequent hospital care must be used.
- (4) Refractions and visual aids.
- (5) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
- (6) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
- (7) Non-therapeutic hysterectomies.
- (8) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
- (9) Medical services considered experimental or investigational.
- (10) Services of a Certified Surgical Assistant.
- (11) Services of a Chiropractor. Payment is made for Chiropractor services on Crossover claims for coinsurance and/or deductible only.
- (12) Services of an independent licensed Physical and/or Occupational Therapist.
- (13) Services of a Psychologist.
- (14) Services of an independent licensed Speech and Hearing Therapist.
- (15) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.
- (16) Payment for more than two nursing facility visits per month.

- (17) More than one inpatient visit per day per physician.
- (18) Payment for removal of benign skin lesions unless medically necessary.
- (19) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
- (20) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
- (21) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
- (22) Mileage.
- (23) A routine hospital visit on the date of discharge unless the member expired.
- (24) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
- (25) Inpatient chemical dependency treatment.
- (26) Fertility treatment.
- (27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

317:30-3-60. General program exclusions - children

(a) The following are excluded from SoonerCare coverage for children:

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

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

(3) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member=s care, the procedure codes for subsequent hospital care must be used.

(4) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

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

(6) Non-therapeutic hysterectomies.

(7) 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).

(8) Medical services considered experimental or investigational.

(9) Services of a Certified Surgical Assistant.

(10) Services of a Chiropractor.

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

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

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

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

(15) Direct payment to perfusionist as this is considered part

of the hospital reimbursement.

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

(17) Mileage.

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

(b) Notwithstanding the exclusions listed in (1)-(18) of subsection (a), the Early and Periodic, Screening, Diagnosis and Treatment Program (EPSDT) provides for coverage of needed medical services normally outside the scope of the medical program when performed in connection with an EPSDT screening and prior authorized.

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

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

(1) Coverage includes the following medically necessary services:

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

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

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

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services. Refer to the Medicare approved list of covered services that can be performed at an ASC.

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

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

(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

(I) Diagnostic x-ray and laboratory services.

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

(K) Obstetrical care.

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

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, OKDHS form 08MA016E, Authorization for Examination and Billing, must accompany the claim.

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

(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form.

Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit.

Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.

(P) Genetic counseling.

(Q) Laboratory testing (such as complete blood count (CBC), platelet count, or urinalysis) for monitoring members receiving chemotherapy, radiation therapy, or medications that require monitoring during treatment.

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

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

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

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

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

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

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

(v) Seeing members without supervision;

(vi) Services provided not for primary purpose of medical

education for the clinical fellow or chief resident;

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

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

(U) 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 signs off on the billed encounter;

(ii) Attending physician is 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.

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

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

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

(W) The payment to a physician for medically directing the services of a CRNA or for the direct supervision of the services of an Anesthesiologist Assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

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

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

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

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

(iii) To be compensable under the SoonerCare program, all

organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

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

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

(i) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure.

(ii) Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.

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

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

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

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

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

(II) Advising the member to quit;

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

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

(V) Arranging for follow-up.

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

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, and Oklahoma State

Health Department and FQHC nursing staff. It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

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

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

(2) General coverage exclusions include the following:

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

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

(C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.

(D) Refractions and visual aids.

(E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

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

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

(H) Non-therapeutic hysterectomies.

(I) Medical services considered experimental or investigational.

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

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

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

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

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

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

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

(Q) Speech and Hearing services.

(R) Mileage.

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

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

(U) Inpatient chemical dependency treatment.

(V) Fertility treatment.

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

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

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

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

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

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

(3) **Procedures for requesting extensions for inpatient services.**

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

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

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

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting

suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.

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

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

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

(C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.

(D) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

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

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

(G) Non-therapeutic hysterectomies

(H) Medical Services considered experimental or investigational.

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

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

(K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing,

tumor board review or multidisciplinary opinion, dictation, and similar functions.

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

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

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

(O) Mileage.

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

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

(1) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment or within one year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for the denial.

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 member, 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 the insertion and/or implantation of contraceptive devices 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) Contraceptive devices
- (D) IV Fluids

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

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

(7) Hearing exams by physician for members 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 members 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 an office visit and an injection of joints performed during the visit if the joint injection code does not have a global coverage designation.

(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 members between ages 21 and 65 for medical diagnosis only.

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

(15) Separate payment is made for the following specimen collections:

- (A) Catheterization for collection of specimen; and
- (B) 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 mileage.

(5) Payment is not made for an office visit where the member 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 SoonerCare 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. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.

(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.

(e) Non-covered inpatient medical services.

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

(2) A hospital admittance 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 the member 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 facility visits per month. The appropriate CPT code is 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 must be supported by a written report.

317:30-5-20. Laboratory services

This Section covers the guidelines for payment of laboratory services by a provider in his/her office, a certified laboratory and for a pathologist's interpretation of laboratory procedures.

(1) **Covered lab services.** Providers may be paid for covered clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a provider refers specimen to a certified laboratory or a hospital laboratory serving outpatients, the certified laboratory or the hospital must bill for performing the test.

(A) Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA).

These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices.

Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from HCFA and have a current contract on file with the OHCA. Payment is made only for those services which fall within the approved specialties/subspecialties.

(B) Reimbursement rate for laboratory procedures is the lesser of the HCFA National 60% fee or the local carrier's allowable (whichever is lower).

(C) All claims for laboratory services are considered medically necessary unless specifically disallowed in this Chapter.

(2) **Compensable outpatient laboratory services.** Medically necessary laboratory services are covered.

(3) **Noncompensable laboratory services.**

(A) Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected by a laboratory.

These services are considered part of the laboratory analysis.

(B) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital rate.

(4) **Covered services by a pathologist.**

(A) A pathologist may be paid for interpretation of inpatient surgical pathology specimen. The appropriate CPT procedure code and modifier is used.

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or Ambulatory Surgery Center setting.

(5) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:

- (A) Tissue examinations for identification of teeth and foreign objects.
- (B) Experimental or investigational procedures.
- (C) Interpretation of clinical laboratory procedures.

317:30-5-42.17. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage:

- (1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
- (2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.
- (3) Reversal of sterilization procedures for the purposes of conception are not covered.
- (4) Medical services considered experimental or investigational.
- (5) Payment for removal of benign skin lesions unless medically necessary.
- (6) Refractions and visual aids.
- (7) Charges incurred while the member is in a skilled nursing or swing bed.

317:30-5-65. Ancillary services

Ancillary services are those items which are not considered routine services. Ancillary services may be billed separately to the SoonerCare program, unless reimbursement is available from Medicare or other insurance or benefit programs. Coverage criteria, utilization controls and program limitations are specified in Part 17 of OAC 317:30-5. Ancillary services are limited to the following services:

- (1) Services requiring prior authorization:
 - (A) Ventilators and supplies.
 - (B) Total Parenteral Nutrition (TPN), and supplies.
 - (C) Custom seating for wheelchairs.
 - (D) Enteral feeding.
- (2) Services not requiring prior authorization:
 - (A) Permanent indwelling or male external catheters and catheter accessories.
 - (B) Colostomy and urostomy supplies.
 - (C) Tracheostomy supplies.
 - (D) Prescription drugs, laboratory procedures, and x-rays.

317:30-5-72.1. Drug benefit

OHCA administers and maintains an Open Formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) and whose manufacturers have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), subject to the following exclusions and limitations.

(1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:

- (A) Agents used to promote fertility.
- (B) Agents primarily used to promote hair growth.
- (C) Agents used for cosmetic purposes.
- (D) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.
- (E) Agents that are experimental or whose side effects make usage controversial.
- (F) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

(2) The drug categories listed in (A) through (E) of this paragraph are covered at the option of the state and are subject to restrictions and limitations. An updated list of products in each of these drug categories is included on the OHCA's public website.

(A) Agents used for the systematic relief of cough and colds. Antihistamines for allergies or antihistamine use associated with asthmatic conditions may be covered when medically necessary and prior authorized.

(B) Vitamins and Minerals. Vitamins and minerals are not covered except under the following conditions:

- (i) prenatal vitamins are covered for pregnant women up to age 50;
- (ii) fluoride preparations are covered for persons under 16 years of age or pregnant; and
- (iii) vitamin D, metabolites, and analogs when used to treat end stage renal disease are covered.

(C) Agents used for smoking cessation. A limited smoking cessation benefit is available.

(D) Coverage of non-prescription or over the counter drugs is limited to:

- (i) Insulin, PKU formula and amino acid bars,

other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions,

(ii) certain smoking cessation products,

(iii) family planning products, and

(iv) OTC products may be covered if the particular product is both cost-effective and clinically appropriate.

(E) Coverage of food supplements is limited to PKU formula and amino acid bars for members diagnosed with PKU, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions when medically necessary and prior authorized.

(3) All covered outpatient drugs are subject to prior authorization as provided in OAC 317-30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

(A) the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. ' 1396r-8; or

(B) the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

317:30-5-211.10. Durable medical equipment (DME)

(a) **DME.** DME includes, but is not limited to: medical supplies, orthotics and prosthetics, custom braces, therapeutic lenses, respiratory equipment and other qualifying items when acquired from a contracted DME provider.

(b) **Certificate of medical necessity.** Certain items of DME require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items include but are not limited to:

- (1) hospital beds;
- (2) support surfaces;
- (3) continuous positive airway pressure devices (BiPAP and CPAP);
- (4) patient lift devices;
- (5) external infusions pumps;
- (6) enteral and parenteral nutrition;
- (7) osteogenesis stimulators; and
- (8) pneumatic compression devices.

(c) **Prior authorization.**

(1) **Rental.** Rental of hospital beds, support surfaces, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts require prior authorization and a completed CMN/OHCA CMN; medical necessity must be documented in the member's medical record and be signed by the physician.

(2) **Purchase.** Equipment will be purchased when a member requires the equipment for an extended period of time. During the prior authorization review the PA consultant may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted. The provider must indicate whether the DME item provided is new or used.

(d) **Backup equipment.** Backup equipment is considered part of the rental cost and not a covered service without prior authorization.

(e) **Home modification.** Equipment used for home modification is not a covered service.

317:30-5-211.17. Wheelchairs

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

(1) "**Assistive technology professional**" or "**ATP**" means a for-service provider who is involved in analysis of the needs and training of a consumer in the use of a particular assistive technology device or is involved in the sale and service of rehabilitation equipment or commercially available assistive technology products and devices.

(2) "**Custom seating system**" means a wheelchair seating system which is individually made for a member using a plaster model of the member, a computer generated model of the member (e.g., CAD-CAM technology), or the detailed measurements of the member to create either:

(A) a molded, contoured, or carved (foam or other suitable material) custom-fabricated seating system that is incorporated into the wheelchair base; or,

(B) a custom seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components which have been configured and attached to the wheelchair base or incorporated into a wheelchair seat and/or back in a manner that the wheelchair could not be easily re-adapted for use by another individual.

(3) "**RESNA**" means the Rehabilitation Engineering and Assistive Technology Society of North America.

(4) "**Specialty evaluation**" means the determination and documentation of the consumer's pathology, history and prognosis, and the physiological, functional, and environmental factors that impact the selection of an appropriate wheeled mobility system.

(b) **Medical Necessity.** Medical necessity pursuant to OAC 317:30-5-211.2 is required for a wheelchair to be covered and reimbursed by SoonerCare.

(c) **Prior authorization.** Prior authorization pursuant to OAC 317:30-5-211.3 is required for a wheelchair to be covered and reimbursed by SoonerCare. All prior authorization requests for the purchase of a wheelchair must indicate the length of the warranty period and what is covered under the warranty.

(1) Wheelchairs, wheelchair parts and accessories, and wheelchair modifications that are beneficial primarily in allowing the member to perform leisure or recreational activities are not considered medically necessary and will not be authorized.

(2) Certain wheelchair parts, accessories, and/or modifications

that are distinctly and separately requested and priced from the original wheelchair request require prior authorization.

(3) OHCA will deny prior authorization requests when the required forms have not been fully completed or the member's medical record does not provide sufficient information to establish medical necessity or to determine that the criteria for coverage has been met.

(d) Coverage and limitations.

(1) For a member who resides in a personal residence, assisted living facility, Intermediate Care Facility for the Mentally Retarded (ICF/MR) or long term care facility, the following criteria must be met for the authorization to purchase a wheelchair.

(A) The member must have a prescription signed by a physician, a physician assistant, or an advanced registered nurse practitioner.

(B) The member must meet the requirements for medical necessity as determined and approved by the Oklahoma Health Care Authority.

(C) The member must either have:

- (i) a specialty evaluation that was performed by a licensed or certified medical professional, such as a physical therapist, occupational therapist, or a physician who has specific training and experience in rehabilitation wheelchair evaluations, and that documents the medical necessity for the wheelchair and its special features; or
- (ii) a wheelchair provided by a supplier that employs a RESNA certified assistive technology professional who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the member.

(2) For members who reside in a long term care facility or ICF/MR, only custom seating systems for wheelchairs are eligible for direct reimbursement to providers of DME services. All standard manual and power wheelchairs are the responsibility of the facility and are considered part of the facility's per diem rate.

(e) Rental, repairs, maintenance and delivery. Refer to OAC 317:30-5-211.4 through 317:30-5-211.5.

(f) Documentation.

(1) The specialty evaluation or wheelchair selection documentation must be submitted with the prior authorization request.

(2) The specialty evaluation or wheelchair selection must be performed no longer than 90 days prior to the submission of the prior authorization request.

(3) The results of the specialty evaluation or wheelchair

selection documentation must be supported by the information submitted on the member's medical record.

(4) A copy of the dated and signed written specialty evaluation or wheelchair selection document must be maintained by the wheelchair provider. The results of the specialty evaluation or wheelchair selection must be written, signed and dated by the medical professional who evaluated the member or the ATP who was involved in the wheelchair selection for the member.

317:30-5-241.3 Behavioral Health Rehabilitation (BHR) services

(a) **Definition.** BHRS are behavioral health remedial services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. This service may include the Evidence Based Practice of Illness, Management, and Recovery.

(1) **Clinical restrictions.** This service is generally performed with only the member(s), but may include the member's family/support system that focuses on the member's diagnosis, management, and recovery based curriculum.

(2) **Qualified providers.** A BHRS, AODTP, or LBHP may perform BHR, following a treatment curriculum approved by a LBHP or AODTP for AOD. Staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE or trauma informed methodology.

(3) **Group sizes.** The minimum staffing ratio is fourteen members for each BHRS, AODTP, or LBHP for adults and eight to one for children under the age of eighteen.

(4) **Limitations.**

(A) **Transportation.** Travel time to and from BHR treatment is not compensable.

(B) **Time.** Breaks, lunchtime and times when the member is unable or unwilling to participate are not compensable and must be deducted from the overall billed time.

(C) **Location.** In order to develop and improve the member's community and interpersonal functioning and self care abilities, rehabilitation may take place in settings away from the outpatient behavioral health agency site. When this occurs, the BHRS, AODTP, or LBHP must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(D) **Billing.** Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic foster home are not eligible for this service, unless prior approved by OHCA or its designated agent.

(i) **Group.** The maximum is 24 units per day for adults and 16 units per day for children.

(ii) **Individual.** The maximum is six units per day. Children under an ODMHSAS Systems of Care program may be prior authorized additional units as part of an intensive transition period.

(b) **Medication training and support.**

(1) **Definition.** Medication Training and Support is a documented

review and educational session by a registered nurse, or physician assistant focusing on a member's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the progress notes. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization.

(2) **Limitations.**

(A) Medication Training and Support may not be billed for SoonerCare members who reside in ICF/MR facilities.

(B) One unit is allowed per month per patient without prior authorization.

(3) **Qualified professionals.** Must be provided by a licensed registered nurse, or a physician assistant as a direct service under the supervision of a physician.

317:35-13-4. Release of medical information

When a SoonerCare member or an authorized representative of a member, applies for services, explicit consent is given for the OHCA to release information to applicable state or federal agencies, medical providers, or an OHCA designee when the information is needed to provide, monitor or approve medical services or obtain payment of those services. Additionally, a physician may release medical information to the member or an authorized representative of the member upon written request. The physician, in such instance, would be governed by the physician-patient relationship.