
POLICY TRANSMITTAL NO. 10-48	DATE: SEPTEMBER 15, 2010
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF INTERGOVERNMENTAL RELATIONS AND POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:2-1-2; 25-7-7; 30-3-5; 30-5-211.5; 30-5-293; 30-5-299;
30-5-555 through 30-5-560.1; 30-5-680; 30-5-1091; and 30-5-1098.

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

In 2007, the OHCA received a Transformation Grant through the Centers for Medicare and Medicaid Services (CMS) to develop a web based online application and eligibility determination system in order to improve the ease and efficiency of enrollment. The Online Enrollment process allows potential members to apply for SoonerCare electronically. Soon, the OHCA will assume responsibility for determining SoonerCare eligibility for certain groups of individuals using this process. As OHCA will now be making eligibility determinations, our appeals' rules are in need of revision to add the responsibility of hearing members' grievances relating to these eligibility determinations.

SoonerCare Choice rules are revised to include procedures and guidelines related to primary care provider (PCP) referrals under the current medical home model. The PCP referral process is clearly defined, including the appropriate use of OHCA administrative referrals. Rules further explain provider expectations and provide guidelines regarding PCP referrals, medical necessity, medical record documentation, and OHCA administrative referrals. These revisions continue to strengthen the OHCA medical home model and SoonerCare Choice program.

OHCA cost-sharing rules are revised to correspond with CMS nominal cost share guidelines pertaining to prescription co-pays. Additionally, rules are clarified to state that a member's cost sharing liability is capped at 5% of the member's gross annual income.

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) rules are revised to provide guidance regarding the delivery of DMEPOS products. Rules provide clarification and guidelines for product refills and reorders, including expected

utilization patterns, member contact, and timelines. Rules also provide additional guidance in regard to products which are supplied and delivered via mail and the appropriate way for providers to bill for such items. Additional revisions include clarification in regard to the provider cost of delivery and additional language to clarify OHCA's intent on DMEPOS supplier maintenance in regard to equipment-related services.

Agency rules are revised to provide guidance in regards to team therapy. Physical, occupational, and speech therapy rules will clarify that when multiple therapists, or therapy assistants, work together as a team to treat one or more SoonerCare members, each therapist or assistant cannot bill separately for the same or different service provided at the same time to the same member. Additionally, rules will provide clarification in regards to billing, multiple therapies, delivery of service, and determining the time counted for service units and codes.

Private duty nursing rules are revised to provide additional clarification in regards to prior authorization requests for such services. Revisions clarify that providers should submit the required OHCA forms and documentation along with the treatment plan when requesting the prior authorization for private duty nursing. Revisions also provide additional flexibility for OHCA to conduct a preliminary telephonic interview with members prior to arranging a personal visit. The additional flexibility in allowing the telephonic interview will provide an opportunity for OHCA to ensure medical necessity prior to arranging the personal home visit. Additional revisions include general policy cleanup as it relates to these sections.

Rules are revised to clarify that smoking and tobacco use cessation counseling is a covered SoonerCare service for the Native American population through the Indian Health Service, Tribally Operated Programs and Urban Indian Clinics. The revision will eliminate any confusion regarding availability of services among I/T/U's providing SoonerCare services.

Original signed on 9-13-10

Mary Stalnaker, Director
Family Support Services Division

Sandra Harrison, Coordinator
Office of Intergovernmental Relations and
Policy

WF # 10-Y (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.

REMOVE

317:2-1-2

317:30-3-5
317:30-5-211.5

317:30-5-555
317:30-5-556
317:30-5-557
317:30-5-558
317:30-5-559
317:30-5-560
317:30-5-560.1

317:30-5-1091
317:30-5-1098

INSERT

317:2-1-2, pages 1-3, revised 8-13-10

317:25-7-7, 1 page only, issued 8-13-10

317:30-3-5, pages 1-3, revised 8-13-10

317:30-5-211.5, pages 1-2, revised 8-13-10

317:30-5-293, 1 page only, issued 8-13-10

317:30-5-299, 1 page only, issued 8-13-10

317:30-5-555, 1 page only, revised 8-13-10

317:30-5-556, 1 page only, revised 8-13-10

317:30-5-557, 1 page only, revised 8-13-10

317:30-5-558, pages 1-2, revised 8-13-10

317:30-5-559, 1 page only, revised 8-13-10

317:30-5-560, 1 page only, revised 8-13-10

317:30-5-560.1, 1 page only, revised 8-13-10

317:30-5-680, 1 page only, issued 8-13-10

317:30-5-1091, 1 page only, revised 8-13-10

317:30-5-1098, pages 1-3, revised 8-13-10

317:2-1-2. Appeals**(a) Member Process Overview.**

(1) The appeals process allows a member to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to file an appeal, the member files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal.

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received within 30 days of written notice sent by OHCA according to Title 68 O.S. ' 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out and necessary documentation not included, then the appeal will not be heard.

(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to OAC 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (Section OAC 317:2-1-13).

(7) Member appeals are ordinarily decided within 90 days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 CFR Section 431.244(f)]

(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within 20 days of the hearing before the ALJ.

(b) Provider Process Overview.

(1) The proceedings as described in this Section contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(c)(2).

(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under OAC 317:2-1-2(c)(2).

(A) The Appellant (Appellant is the provider who files a grievance) files an LD form requesting a grievance hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider grievances and LD-3 forms are for nursing home wage enhancement grievances.)

(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(C) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(D) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.

(E) The Administrative Law Judge's decision is appealable to OHCA's CEO under OAC 317:2-1-13.

(c) **ALJ jurisdiction.** The administrative law judge has jurisdiction of the following matters:

(1) Member Appeals:

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;

(E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and

(F) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

(G) Appeals which relate to eligibility determinations made by OHCA; and

(2) Provider Appeals:

- (A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;
- (B) Denial of request to disenroll member from provider's SoonerCare Choice panel;
- (C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5), (e)(8), and (e)(12);
- (D) Petitions for Rulemaking;
- (E) Appeals of insureds participating in Insure Oklahoma/O-EPIC which are authorized by OAC 317:45-9-8(a);
- (F) Appeals to the decision made by the Contracts manager related to reports of supplier non-compliance to the Central Purchasing Division, Oklahoma Department of Central Services and other appeal rights granted by contract;
- (G) Drug rebate appeals;
- (H) Nursing home contracts which are terminated, denied, or non-renewed;
- (I) Proposed administrative sanction appeals pursuant to OAC 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions; and
- (J) Contract award appeals.

317:25-7-7. Referrals for specialty services

(a) PCPs are required to assure the delivery of medically necessary preventive and primary care medical services, including securing referrals for specialty services. Some services, as defined in OAC 317:25-7-2(c) and OAC 317:25-7-10(b), do not require a referral from the PCP. A PCP referral does not guarantee payment, as all services authorized by the PCP must be in the scope of coverage of the SoonerCare Choice program to be considered compensable.

(b) Pursuant to OAC 317:30-3-1(f), SoonerCare Choice referrals must always be made on the basis of medical necessity. Referrals from the PCP are required prior to receiving the referred service, except for retrospective referrals as deemed appropriate by the PCP.

(c) Documentation in the medical record must include a copy of each referral to another health care provider. The PCP and specialty provider are responsible for maintaining appropriate documentation of each referral to support the claims for medically necessary services.

(d) As approved and deemed appropriate, the OHCA may provide administrative referrals for specialty services. Administrative referrals are only provided by the OHCA under special and extenuating circumstances. Administrative referrals should not be requested as a standard business practice. The OHCA will not process retrospective administrative referrals, unless one of the following exceptions applies:

(1) the specialty services are referred from an IHS, tribal, or urban Indian clinic;

(2) the specialty services are referred as the result of an emergency room visit or emergency room follow-up visit;

(3) the specialty services are referred for pre-operative facility services prior to a dental procedure; or

(4) the retrospective administrative referral request for specialty services is requested from the OHCA within 30 calendar days of the specialty care date of service. If the retrospective administrative referral is requested within the 30 calendar days, the request must include appropriate documentation for the OHCA to approve the request. Appropriate documentation must include:

(A) proof that the specialist has attempted to collect a PCP referral from the member's assigned PCP; and

(B) medical documentation to substantiate that the specialty services are medically necessary pursuant to OAC 317:30-3-1(f).

(e) Nothing in this section is intended to absolve the PCP of their obligations in accordance with the conditions set forth in their PCP SoonerCare Choice contract and the rules delineated in OAC

317:30.

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 SoonerCare Choice 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 SoonerCare Choice contracts in the SoonerCare Program.

(b) **Assignment in fee-for-service.** The OHCA'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 co-payment required by the State Plan to be paid by the member and make no additional charges to the member 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 member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member 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, Provider Services.

(3) When potential assignment violations are detected, the OHCA 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 OHCA 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 SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.

(1) If the service provided to the member is outside of the

scope of the services outlined in the SoonerCare Contract, then the provider may bill or seek collection from the member.

(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) 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.

(3) 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 members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the fee for service program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges and it does not preclude the provider from attempting to collect the co-payment.

(1) Co-payment is not required of the following members:

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

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

(C) Pregnant women.

(D) Home and Community Based Service waiver members except for prescription drugs.

(2) Co-payment 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) Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

(C) Ambulatory surgery visits including free-standing ambulatory surgery centers.

- (D) Encounters with the following rendering providers:
 - (i) Physicians,
 - (ii) Advanced Practice Nurses,
 - (iii) Physician Assistants,
 - (iv) Optometrists,
 - (v) Home Health Agencies,
 - (vi) Certified Registered Nurse Anesthetists, and
 - (vii) Anesthesiologist Assistants,
 - (viii) Durable Medical Equipment providers, and
 - (ix) Outpatient behavioral health providers.
 - (E) Prescription drugs.
 - (i) Zero for preferred generics.
 - (ii) \$0.65 for prescriptions having a SoonerCare allowable payment of \$0.00-\$10.00.
 - (iii) \$1.20 for prescriptions having a SoonerCare allowable payment of \$10.01-\$25.00.
 - (iv) \$2.40 for prescriptions having a SoonerCare allowable payment of \$25.01-\$50.00.
 - (v) \$3.50 for prescriptions having a SoonerCare allowable payment of \$50.01 or more.
 - (F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.
- (4) Aggregate cost-sharing liabilities in a given calendar year may not exceed 5% of the member's gross annual income.

317:30-5-211.5. Repairs, maintenance, replacement and delivery

(a) **Repairs.** Repairs to equipment that a member owns are covered when they are necessary to make the equipment usable. The repair charge includes the use of "loaner" equipment as required. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, payment can not be made for the amount in excess.

(b) **Maintenance.** Routine periodic servicing, such as testing, cleaning, regulating, and checking the member's equipment is considered maintenance and not a separate covered service. DMEPOS suppliers must provide equipment-related services consistent with the manufacturer's specifications and in accordance with all federal, state and local laws and regulations. Equipment-related services may include, but are not limited to, checking oxygen system purity levels and flow rates, changing and cleaning filters, and assuring the integrity of equipment alarms and back-up systems. However, more extensive maintenance as recommended by the manufacturer and performed by authorized technicians is considered repairs. This may include breaking down sealed components and performing tests that require specialized testing equipment not available to the member. The supplier of a capped rental item that supplied the item the 13th month must provide maintenance and service for the item. In very rare circumstances of malicious damage, culpable neglect, or wrongful disposition, the supplier may document the circumstances and be relieved of the obligation to provide maintenance and service.

(c) **Replacement.**

(1) If a capped rental item of equipment has been in continuous use by the member for the equipment's useful life or if the item is irreparably damaged, lost, or stolen, a prior authorization must be submitted to obtain new equipment. The reasonable useful life for capped rental equipment cannot be less than five years. Useful life is determined by the delivery of the equipment to the member, not the age of the equipment.

(2) Replacement parts must be billed with the appropriate HCPCS code that represents the item or part being replaced, along with a pricing modifier and replacement modifier. If a part that has not been assigned a HCPCS code is being replaced, the provider should use a miscellaneous HCPCS code to bill each part. Each claim that contains miscellaneous codes for replacement parts must include a narrative description of the item, the brand name, model name/number of the item and an invoice.

(d) **Delivery.** DMEPOS products are set with usual maximum quantities and frequency limits. Suppliers are not expected to provide these amounts routinely, nor are members required to accept

DMEPOS products at frequencies or in quantities that exceed the amount the member would typically use. Suppliers must not dispense a quantity of any DMEPOS product exceeding a member's expected utilization. The reordering or refilling of DMEPOS products should always be based on actual member usage. Suppliers should stay attuned to atypical utilization patterns on behalf of their members and verify with the ordering physician that the atypical utilization is warranted. Suppliers must exercise the following guidelines in regard to the delivery of DMEPOS products:

(1) For DMEPOS products that are supplied as refills to the original order, suppliers must contact the member prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order. Contact with the member regarding refills should take place no sooner than 7 days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier must deliver the DMEPOS product no sooner than 5 days prior to the end of the usage for the current product. This is regardless of which delivery method is utilized. A member must specifically request the refill before a supplier dispenses the product. Suppliers must not automatically dispense a quantity of supplies on a predetermined basis, even if the member has authorized this in advance. The supplier must have member contact documentation on file to substantiate that the DMEPOS product was refilled in accordance with this section.

(2) For DMEPOS products that are supplied via mail order, suppliers must bill using the appropriate modifier which indicates that the DMEPOS product was delivered via the mail. Reimbursement for DMEPOS products supplied and delivered via mail may be at a reduced rate.

(3) For DMEPOS products that are covered in the scope of the SoonerCare program, the cost of delivery is always included in the rate for the covered item(s).

317:30-5-293. Team therapy (Co-treatment)

Therapists, or therapy assistants, working together as a team to treat one or more members cannot each bill separately for the same or different service provided at the same time to the same member.

(1) CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one member at the same time, only one therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two therapists, each service unit of time the member is being treated can count as only one unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

317:30-5-299. Team therapy (Co-treatment)

Therapists, or therapy assistants, working together as a team to treat one or more members cannot each bill separately for the same or different service provided at the same time to the same member.

(1) CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one member at the same time, only one therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two therapists, each service unit of time the member is being treated can count as only one unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

317:30-5-555. Eligible providers

(a) An organization who desires to be paid by SoonerCare for private duty nursing must meet the following requirements prior to providing services to eligible SoonerCare members:

- (1) an executed contract with OHCA, and
- (2) the organization must meet the requirements of OAC 317:30-5-545 or it must be licensed by the State Health Department as a Home Care Agency.

(b) The provider of services within the organization must be a licensed practical nurse or a registered nurse.

317:30-5-556. Definitions

Private duty nursing is medically necessary care provided on a regular basis by a Licensed Practical Nurse or Registered Nurse in the member's residence or to assist outside the home during transport to medical appointments and emergency room visits in lieu of transport by ambulance.

317:30-5-557. Coverage by category

(a) **Adults.** SoonerCare does not cover adults (Age 21 or over) for private duty nursing with the exception of subsection (c).

(b) **Children.** SoonerCare does cover children (Under the age of 21) if:

(1) the child is eligible for SoonerCare; and

(2) the Oklahoma Health Care Authority, in its discretion, deems the services medically necessary. Medical necessity is determined in accordance with OAC 317:30-5-560.1.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the SoonerCare allowable for comparable services.

317:30-5-558. Private duty nursing coverage limitations

The following regulations apply to all private duty nursing services and provide coverage limitations:

(1) All services must be prior authorized to receive payment from the Oklahoma Health Care Authority (OHCA). Prior authorization means authorization in advance of services provided in accordance with OAC 317:30-5-560.1;

(2) A treatment plan must be completed by the Nursing agency before requesting prior authorization and must be updated at least annually and signed by the physician;

(3) A telephonic interview and/or personal visit by an OHCA Care Management Nurse is required prior to the authorization for services;

(4) Care in excess of the designated hours per day granted in the prior authorization is not SoonerCare compensable. Prior-authorized but unused service hours cannot be "banked," "saved," or otherwise "accumulated" for use at a future date or time. If such hours or services are provided, they are not SoonerCare compensable.

(5) Any care provided outside of the home is limited to assisting during transport to medical appointments and emergency room visits in lieu of transport by ambulance and is limited to the number of hours requested on the treatment plan and approved by OHCA.

(6) Private duty nursing services do not include office time or administrative time in providing the service. The time billed is for direct nursing services only.

(7) Staff must be engaged in purposeful activity that directly benefits the member receiving services. Staff must be physically able and mentally alert to carry out the duties of the job. At no time will OHCA compensate an organization for nursing staff time when sleeping.

(8) OHCA will not approve Private Duty Nursing service if all health and safety issues cannot be met in the home setting.

(9) A provider must not misrepresent or omit facts in a treatment plan.

(10) It is outside the scope of coverage to deliver care in a manner outside the treatment plan or to deliver units over the authorized units of care.

(11) Private duty nursing is not authorized in excess of 16 hours per day except immediately following a hospital stay or the temporary incapacitation of the primary caregiver. Under these two exceptions, care in excess of 16 hours is authorized for a period up to 30 days. As expressed in this subsection, incapacity means an involuntary ability to provide care.

(12) Family and/or caregivers and/or guardians are required to

provide some of the nursing care to the member without compensation.

317:30-5-559. How services are authorized

An eligible provider may have private duty nursing services authorized by following all the following steps:

- (1) create a treatment plan for the patient as expressed in OAC 317:30-5-560;
- (2) submit the prior authorization request with the appropriate OHCA required forms, the treatment plan, and request the telephonic interview and/or personal visit by an OHCA Care Management Nurse; and
- (3) have an OHCA Care Management Nurse determine medical necessity of the service by scoring the member's needs on the Private Duty Nursing Acuity Grid.

317:30-5-560. Treatment Plan

(a) An eligible organization must create a treatment plan for the member as part of the authorization process for private duty nursing services. The initial treatment plan must be signed by the member's attending physician. It must be updated and signed annually.

(b) The treatment plan must include all of the following medical and social data so that an OHCA Care Management Nurse can appropriately determine medical necessity by the use of the Private Duty Nursing Acuity Grid:

- (1) diagnosis;
- (2) prognosis;
- (3) anticipated length of treatment;
- (4) number of hours of private duty nursing requested per day;
- (5) assessment needs and frequency (e.g., vital signs, glucose checks, neuro checks, respiratory);
- (6) medication method of administration and frequency;
- (7) age-appropriate feeding requirements (diet, method and frequency);
- (8) respiratory needs;
- (9) mobility requirements including need for turning and positioning, and the potential for skin breakdown;
- (10) developmental deficits;
- (11) casting, orthotics, therapies;
- (12) age-appropriate elimination needs;
- (13) seizure activity and precautions;
- (14) age-appropriate sleep patterns;
- (15) disorientation and/or combative issues;
- (16) age-appropriate wound care and/or personal care;
- (17) communication issues;
- (18) social support needs;
- (19) name, skill level, and availability of all caregivers; and
- (20) other pertinent nursing needs such as dialysis, isolation.

317:30-5-560.1. Prior authorization requirements

- (a) Authorizations are provided for a maximum period of six months.
- (b) Authorizations require:
 - (1) a treatment plan for the member; and
 - (2) a telephonic interview and/or personal visit by an OHCA Care Management Nurse to determine medical necessity using the Private Duty Nursing Acuity Grid.
- (c) The number of hours authorized may differ from the hours requested on the treatment plan based on the assessment of the Care Management Nurse.
- (d) If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization.
- (e) Changes in the treatment plan may necessitate another telephonic interview and/or personal visit by the OHCA Care Management staff.

317:30-5-680. Team therapy (Co-treatment)

Therapists, or therapy assistants, working together as a team to treat one or more members cannot each bill separately for the same or different service provided at the same time to the same member.

(1) CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one member at the same time, only one therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two therapists, each service unit of time the member is being treated can count as only one unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

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

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

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

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

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

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

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

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

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

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

(6) Public health nursing services include but are not limited to services in the following areas:

(A) Phlebotomy;

(B) Wound care;

(C) Public health education;

(D) Administration of immunizations;

(E) Administration of medication;

(F) Child health screenings meeting EPSDT criteria;

(G) Smoking and Tobacco Use Cessation Counseling;

(H) Prenatal, newborn and postpartum assessments, including case management services for first time mothers; and

(I) General health assessments and management of conditions such as tuberculosis, diabetes and hypertension.

(7) Visiting nurse services to the homebound;

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

(9) Dental services.

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

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

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

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

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

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

- (1) Medical;
- (2) Diagnostic;
- (3) Behavioral Health services [refer to OAC 317:30-5-1094];
- (4) Dental, Medical and Mental Health Screenings;
- (5) Vision;
- (6) Physical Therapy;
- (7) Occupational Therapy;
- (8) Podiatry;
- (9) Speech;
- (10) Hearing;
- (11) Visiting Nurse Services;
- (12) Smoking and Tobacco Use Cessation Counseling
- (13) Other Title XIX or XXI services as allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules;
- (14) Drugs or medication treatments provided during a clinic visit are part of the encounter rate. For example, a member has come into the clinic with high blood pressure and is treated at the clinic with a hypertensive drug or drug sample. Drug samples are included in the encounter rate. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;
- (15) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or

intermittent basis to home-bound members; and
(16) I/T/U Multiple Outpatient Encounters.

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

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

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

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

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

- (i) A well child check and an immunization;
- (ii) A preventive dental screen and fluoride varnish application in a single setting;
- (iii) A medical encounter with a mental health or addiction diagnosis on the same day as a mental health or addiction encounter;
- (iv) A mental health and addiction encounter with similar diagnosis;
- (v) Any time a member receives only a partial service with one provider and partial service from another provider. This would be considered a single encounter.

(d) More than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. This does not imply that if a member is seen at a single office visit with multiple problems that multiple encounters can be billed. For example, a member comes to the clinic in the morning for an immunization, and in the afternoon, the member falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two

encounters. However, a member who comes to the I/T/U facility for a prenatal visit in the morning and delivers in the afternoon would not be considered a distinctly different diagnosis and can only be billed as a single encounter.

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

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

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