
POLICY TRANSMITTAL NO. 07-73	DATE: DECEMBER 20, 2007
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS AND POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-3-59; 30-5-22 through 30-5-22.1; 30-5-70.2; 317:30-5-111; 317:30-5-204 through 30-5-210; 30-5-211.13; 30-5-219 through 30-5-221; 30-5-230 through 30-5-235; 30-5-290; 35-5-8; 35-6-15; 35-7-15; 35-7-48; 45-9-1; 45-11-11; and 45-11-20.

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

Application procedure rules for medical assistance are revised to allow the acceptance of facsimile signatures on all SoonerCare applications and do not require an original signature to be obtained. Agency rules are revised to: (1) remove inconsistencies in rules for payment of adult therapies in the inpatient and outpatient hospital settings. Therapy services for adult SoonerCare members are only compensable when provided on an inpatient or outpatient hospital basis; (2) comply with Public Law 110-28 known as the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 requiring prescriptions in written form to be executed on tamper-resistant prescriptions pads in order to qualify for reimbursement by SoonerCare; (3) increase the current O-EPIC Employer Sponsored Insurance (ESI) and O-EPIC Individual Plan (IP) maximum income standards from 185% to 200% of the federal poverty level; (4) delay the SoonerCare requirement of accreditation by a Medicare deemed accreditation organization for quality standards for providers of durable medical equipment, prosthetics, orthotics and supplies until January 1, 2011; (5) add Licensed Genetic Counselors to individual providers and specialties who provide health care to SoonerCare members; (6) add Maternal and Infant Health Licensed Clinical Social Workers to individual providers and specialties who provide health care to SoonerCare members; (7) add enhanced services for medically high risk pregnancies and allow additional reimbursement to an obstetrical care provider treating a member who is confirmed to be medically/obstetrically "high risk"; (8) add Registered Lactation Consultants and International Board Certified Lactation Consultants to individual providers and specialties who provide health care to SoonerCare members; and (9) allow an exception for coverage of

external breast prosthesis in instances where a woman with breast cancer receives reconstruction following a mastectomy, but the breast implant fails or ruptures and circumstances are such that an implant replacement is not recommended by the surgeon and/or desired by the member.

Eligibility rules for the SoonerPlan Program (Family Planning Waiver services) are revised to: (1) allow an applicant/member who wants family planning services only to enroll in SoonerPlan even if they may be otherwise eligible for SoonerCare; and (2) allow closure of SoonerPlan benefits when the applicant/member has undergone a sterilization procedure.

Oklahoma Employer and Employee Partnership for Insurance Coverage Individual Plan rules are revised to exclude as covered benefits services of an International Board Certified Lactation Consultant, Maternal and Infant Health Licensed clinical Social Worker, and enhanced services for medically high risk pregnancies as found in OAC 317:30-5-22.1.

Original signed on 11-30-07

Mary Stalnaker, Director
Family Support Services Division

Sharon Neuwald, Coordinator
Office of Legislative Relations and Policy

WF # 07-II (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>
317:30-3-59	317:30-3-59, pages 1-2, revised 10-1-07
317:30-5-22	317:30-5-22, pages 1-3, revised 11-1-07
-----	317:30-5-22.1, 1 page only, issued 11-1-07
317:30-5-70.2	317:30-5-70.2, 1 page only, revised 10-1-07
317:30-5-111	317:30-5-111, pages 1-2, revised 10-1-07
-----	317:30-5-204, 1 page only, issued 11-1-07
-----	317:30-5-205, 1 page only, issued 11-1-07
-----	317:30-5-206, 1 page only, issued 11-1-07
-----	317:30-5-207, 1 page only, issued 11-1-07
-----	317:30-5-208, 1 page only, issued 11-1-07
-----	317:30-5-209, 1 page only, issued 11-1-07
317:30-5-210	317:30-5-210, 1 page only, revised 11-1-07
317:30-5-211.13	317:30-5-211.13, 1 page only revised 12-1-07
-----	317:30-5-219, 1 page only, issued 11-1-07
-----	317:30-5-220, 1 page only, issued 11-1-07

REMOVE

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-----	317:30-5-221, 1 page only, issued 11-1-07
-----	317:30-5-230, 1 page only, issued 12-1-07
-----	317:30-5-231, 1 page only, issued 12-1-07
-----	317:30-5-232, 1 page only, issued 12-1-07
-----	317:30-5-233, 1 page only, issued 12-1-07
-----	317:30-5-234, 1 page only, issued 12-1-07
-----	317:30-5-235, 1 page only, issued 12-1-07
317:30-5-290	-----
317:35-5-8	317:35-5-8, 1 page only, revised 10-1-07
317:35-6-15	317:35-6-15, pages 1-2, revised 11-1-07
317:35-7-15	317:35-7-15, pages 1-2, revised 11-1-07
317:35-7-48	317:35-7-48, 1 page only, revised 10-1-07
317:45-9-1	317:45-9-1, 1 page only, revised 10-1-07
317:45-11-11	317:45-11-11, pages 1-2, revised 12-1-07
317:45-11-20	317:45-11-20, pages 1-2, revised 10-1-07

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

The following are excluded from SoonerCare coverage for adults:

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

(4) Refractions and visual aids.

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

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

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

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

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

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

(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.

(9) Medical services considered to be experimental.

(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 Therapist.

(13) Services of a Psychologist.

**MEDICAL PROVIDERS-FEE FOR SERVICE
GENERAL MEDICAL PROGRAM INFORMATION**

OAC 317:30-3-59 (p2)

(14) Services of an independent licensed Speech and Hearing Therapist.

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

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

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

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

317:30-5-22. Obstetrical care

(a) Obstetrical (OB) care is billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery is used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total obstetrical care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the ante partum visits. The ante partum care during the prenatal care period includes all care by the OB attending physician except major illness distinctly unrelated to the pregnancy.

(b) Procedures paid separately from total obstetrical care are listed in (1) - (6) of this subsection.

(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form and the most recent version of the Oklahoma Health Care Authority's Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one assessment per provider and no more than two per pregnancy.

(2) Medically necessary real time ante partum diagnostic ultrasounds will be paid for in addition to ante partum care, delivery and post partum obstetrical care under defined circumstances. To be eligible for payment, ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).

(A) One abdominal or vaginal ultrasound will be covered in the first trimester of pregnancy. The ultrasound must be performed by a board certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in Obstetrical ultrasonography.

(B) One ultrasound after the first trimester will be covered. This ultrasound must be performed by a board certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification in Obstetrical ultrasonography.

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

OAC 317:30-5-22 (p2)

(C) Additional ultrasounds, including detailed ultrasounds and re-evaluations of previously identified or suspected fetal or maternal anomalies, must be performed by an active candidate or Board Certified diplomat in Maternal-Fetal Medicine.

(3) Standby attendance at Cesarean Section (C-Section), for the purpose of attending the baby, is compensable when billed by a physician not participating in the delivery.

(4) Spinal anesthesia administered by the attending physician is a compensable service and is billed separately from the delivery.

(5) Amniocentesis is not included in routine obstetrical care and is billed separately.

(6) Additional payment is not made for the delivery of twins. If one twin is delivered vaginally and one is delivered by C-section by the same physician, the higher level procedure is paid. If one twin is delivered vaginally and one twin is delivered by C-Section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment is not made to the same physician for both standby and assistant at C-Section.

(c) Assistant surgeons are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at C-Section should bill separately for the prenatal and the six weeks postpartum office visit.

(d) Procedures listed in (1) - (5) of this subsection are not paid or not covered separately from total obstetrical care.

(1) Non-stress tests.

(2) Standby at C-Section is not compensable when billed by a physician participating in delivery.

(3) Payment is not made for assistant surgery for obstetrical procedures which include prenatal or post partum care.

(4) An additional allowance is not made for induction of labor, double set-up examinations, fetal stress tests, or pudendal anesthetic. Providers must not bill separately for these procedures.

(5) Fetal scalp blood sampling is considered part of the total OB care.

(e) Obstetrical coverage for children is the same as for adults with additional procedures being covered due to EPSDT provisions if determined to be medically necessary.

(1) Services, deemed medically necessary and allowable under federal Medicaid regulations, are covered by the EPSDT/OHCA Child Health program even though those services may not be part of the Oklahoma Health Care Authority SoonerCare program. Such

services must be prior authorized.

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

317:30-5-22.1. Enhanced Services for Medically High Risk Pregnancies

(a) **Enhanced Services.** Enhanced services are available for pregnant women eligible for SoonerCare and are in addition to services for uncomplicated maternity cases. Women deemed high risk based on criteria established by the OHCA may receive prior authorization for medically necessary enhanced benefits which include:

- (1) prenatal at risk ante partum management;
- (2) a combined maximum of 12 fetal non stress test(s) and biophysical profiles; and
- (3) a maximum of 6 repeat ultrasounds not covered under OAC 317:30-5-22(b)(2).

(b) **Prior Authorization.** In order to receive enhanced services, the following documentation must be received by the OHCA Medical Authorizations Unit for review/approval:

- (1) ACOG or other comparable comprehensive assessment;
- (2) chart note identifying and detailing the qualifying high risk condition; and
- (3) a treatment plan signed by the primary provider of obstetric care, a Maternal Fetal Medicine specialist who has agreed to provide collaborative care, and the SoonerCare member. The treatment plan must contain the following:
 - (A) a description of care to be provided by the Maternal Fetal Medicine specialist;
 - (B) a description of care to be provided by the primary provider of obstetrical care;
 - (C) anticipated number of non stress test(s) and biochemical profiles needed (if applicable); and
 - (D) anticipated number of follow-up ultrasounds needed.

(c) **Reimbursement.** Enhanced benefits will be reimbursed as follows:

- (1) ante partum management for high risk will be reimbursed to the primary provider of obstetrical care.
- (2) reimbursement for enhanced at risk ante partum management will not be available to physicians who already qualify for enhanced reimbursement as state employed physicians.
- (3) reimbursement for enhanced at risk ante partum management will not be made during an in-patient hospital stay.

317:30-5-70.2. Record retention/ Post Payment Review

Post-payment audits of the SoonerCare program are performed routinely by state and federal agencies. This Section applies to any post-payment audit regardless of the agency performing the audit. Pharmacies are selected at random for audits. The Pharmacy is required to provide original written prescriptions and signature logs as well as purchase invoices and other records necessary to document their compliance with program guidelines at the time of the audit. Written prescriptions must conform with the standards set forth in 42 USC 1396b(i) and related federal regulations requiring the use of a tamper-resistant prescription pad. These standards do not apply to prescriptions transmitted via telephone, facsimile or electronic prescription systems. Original written prescriptions are defined as any order for drug or medical supplies written or signed, or transmitted by word of mouth, telephone or other means of communication by a practitioner licensed by law to prescribe such drugs and medical supplies intended to be filled, compounded, or dispensed by a pharmacist. Signature logs are defined as any document which verifies that the prescription was delivered to the member or their representative. This may include electronic forms of tracking including but not limited to scanning a bar code of the filled prescription. The electronic tracking system must be able to produce a copy of the scan for audit purposes. Failure to provide the requested information to the Reviewer may result in a recommendation ranging from a potential recoupment of SoonerCare payments for the service to contract termination.

317:30-5-111. Coverage for adults

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

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

(2) All inpatient stays are subject to post-payment utilization review by the OHCA's designated Quality Improvement Organization (QIO). These reviews are based on severity of illness and intensity of treatment.

(A) It is the policy and intent of OHCA to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a SoonerCare member. If the QIO, upon their initial review determines the admission should be denied, a notice is issued to the facility and the attending physician advising them of the decision. This notice also advises that a reconsideration request may be submitted within the specified time frame on the notice and consistent with the Medicare guidelines. Additional information submitted with the reconsideration request is reviewed by the QIO that utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, the QIO sends written notification of the denial decision to the hospital, attending physician and the OHCA. Once the OHCA has been notified, the overpayment is processed as per the final denial determination.

(B) If the hospital or attending physician did not request reconsideration from the QIO, the QIO informs OHCA there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, processes the overpayment as per the denial notice sent to the OHCA by the QIO.

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

(3) If a hospital or physician believes that a hospital admission or continued stay is not medically necessary and thus not compensable but the member insists on treatment, the member

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

OAC 317:30-5-111 (p2)

should be informed that he/she will be personally responsible for all charges. If a claim is filed and paid and the service is later denied, the patient is not responsible.

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

(5) Outpatient services for adults are covered as listed in OAC 317:30-5-42.1.

**MEDICAL PROVIDERS-FEE FOR SERVICE
MATERNAL AND INFANT HEALTH LICENSED
CLINICAL SOCIAL WORKERS SPECIFIC**

OAC 317:30-5-204

317:30-5-204. General Information

The emphasis of maternal and infant health licensed clinical social work services is on providing psychosocial support, health and behavior assessment and intervention focused on biopsychosocial factors related to the member's perinatal health status. These services are intended for women who are at risk due to drug/alcohol use, domestic violence, lack of stable food/shelter, have high risk medical conditions, problems in the post partum environment that interfere with the infant health and bonding and/or other psychosocial concerns.

**MEDICAL PROVIDERS-FEE FOR SERVICE
MATERNAL AND INFANT HEALTH LICENSED
CLINICAL SOCIAL WORKERS SPECIFIC**

OAC 317:30-5-205

317:30-5-205. Eligible Providers

Eligible providers are Licensed Clinical Social Workers (LCSWs) with a minimum of six hours of continuing education or technical assistance in the area of Maternal and Infant Health. LCSWs must have a current contract on file with the Oklahoma Health Care Authority and be licensed in the state in which the service is being provided. Services may also be provided through the Department of Health or other county health departments. Services provided through the health departments must be provided by a LCSW.

In the event of a post-payment audit, LCSWs providing Maternal and Infant Health Clinical Social Work services must be able to demonstrate that they have completed at least six hours of continuing education or technical assistance for each calendar year of providing care to SoonerCare members. The continuing education or technical assistance must be in the area of Maternal and Infant Health relevant to the provision of Social Work Services.

**MEDICAL PROVIDERS-FEE FOR SERVICE
MATERNAL AND INFANT HEALTH LICENSED
CLINICAL SOCIAL WORKERS SPECIFIC**

OAC 317:30-5-206

317:30-5-206. Coverage

Maternal and infant health social work services are covered for pregnant and postpartum women for whom a psychosocial condition exists that may negatively impact the pregnancy and/or well being of the newborn infant. SoonerCare members may self-refer or be referred by any provider. Identification of the condition may be based on a CH-16 or the Licensed Clinical Social Worker's initial assessment. Psychosocial assessment/counseling is appropriate in order to develop a social work care plan based upon the health risks due to psychosocial factors.

**MEDICAL PROVIDERS-FEE FOR SERVICE
MATERNAL AND INFANT HEALTH LICENSED
CLINICAL SOCIAL WORKERS SPECIFIC**

OAC 317:30-5-207

317:30-5-207. Limitations

Coverage limitations for maternal and infant health social work services are as follows:

(1) Services are only covered when performed in the LCSWs' office setting, patient's home or other confidential clinic setting.

(2) No separate reimbursement will be made to a facility.

(3) Services billed by a contracted LCSW must be provided face-to-face and in an individual setting.

**MEDICAL PROVIDERS-FEE FOR SERVICE
MATERNAL AND INFANT HEALTH LICENSED
CLINICAL SOCIAL WORKERS SPECIFIC**

OAC 317:30-5-208

317:30-5-208. Reimbursement

(a) Maternal and infant health social work services must be billed using appropriate CPT codes and guidelines.

(b) SoonerCare does not allow more than 32 units (15 minutes = 1 unit) during the pregnancy which includes 60 days postpartum.

(c) LCSWs that are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

(d) Only the LCSW directly performing the care or a county health department may bill the SoonerCare Program.

(e) The time indicated on the claim form must be the time actually spent with the member.

317:30-5-209. Documentation

All services must be reflected by documentation in the patient records. All assessment and treatment services must include the following:

- (1) date;
- (2) start and stop time for each timed treatment session;
- (3) signature of the service provider;
- (4) credentials of service provider;
- (5) documentation of the referral source;
- (6) problems(s), goals and/or objectives identified on the treatment plan;
- (7) methods used to address the problem(s), goals and objectives;
- (8) progress made toward goals and objectives;
- (9) patient response to the session or intervention; and
- (10) any new problem(s), goals and/or objectives identified during the session.

317:30-5-210. Eligible providers

All eligible medical suppliers must have a current contract with the Oklahoma Health Care Authority. The supplier must comply with all applicable State and Federal laws. Effective January 1, 2011, all suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) must be accredited by a Medicare deemed accreditation organization for quality standards for DMEPOS suppliers in order to bill the SoonerCare program. OHCA may make exceptions to this standard if it is determined that a supplier may provide acceptable service to an under served location.

317:30-5-211.13. Prosthetic devices

Prosthetic devices prescribed by an appropriate medical provider as conditioned in this section are covered items.

(1) **Certificate of medical necessity.** The medical supplier must have a fully completed CMN on file for prosthetic items including Transcutaneous Electric Nerve Stimulators (TENS).

(2) **Prior authorization.** Prosthetic devices, except for cataract lenses, require prior authorization.

(3) **Home dialysis.** Equipment and supplies are covered items for members receiving home dialysis treatments only.

(4) **Nerve stimulators.** Payment is made for rental equipment which must not exceed the purchase price, for transcutaneous nerve stimulators, implanted peripheral nerve stimulators, and neuromuscular stimulators. After continuous rental for 13 months, the equipment becomes the property of the OHCA to be used by the member until no longer medically necessary.

(5) **Breast prosthesis, bras, and prosthetic garments.**

(A) Payment is limited to:

(i) one prosthetic garment with mastectomy form every 12 months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(ii) two mastectomy bras per year; and

(iii) one silicone or equal breast prosthetic per side every 24 months; or

(iv) one foam prosthetic per side every six months.

(B) Payment will not be made for both a silicone and a foam prosthetic in the same 12 month period.

(C) Breast prostheses, bras, and prosthetic garments must be purchased from a Board Certified Mastectomy Fitter.

(D) A breast prosthesis can be replaced if:

(i) lost;

(ii) irreparably damaged (other than ordinary wear and tear); or

(iii) the member's medical condition necessitates a different type of item and the physician provides a new prescription explaining the need for a different type of prosthesis.

(E) External breast prostheses are not covered after breast reconstruction is performed except in instances where a woman with breast cancer receives reconstructive surgery following a mastectomy, but the breast implant fails or ruptures and circumstances are such that an implant replacement is not recommended by the surgeon and/or desired by the member.

(6) **Prosthetic devices inserted during surgery.** Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

317:30-5-219. General Information

Genetic counseling gathers critical family history, patient history, and other factors to be analyzed and shared with the member to help them understand and adapt to the medical, psychosocial and familial contributions to potential or realized birth defects.

**MEDICAL PROVIDERS-FEE FOR SERVICE
GENETIC COUNSELORS SPECIFIC**

OAC 317:30-5-220

317:30-5-220. Eligible Providers

Eligible providers must be Licensed Genetic Counselors. Genetic Counselors must have a current contract on file with the Oklahoma Health Care Authority and be licensed in the state in which the service is being provided.

317:30-5-221. Coverage

(a) Services for pregnant/postpartum SoonerCare members must be referred by a provider involved in the provision of obstetric or pediatric care. Members are eligible for genetic counseling during pregnancy which includes 60 days postpartum. Reasons for genetic counseling include but are not limited to the following:

(1) advanced maternal age;

(2) abnormal maternal serum first or second screening;

(3) previous child or current fetus/infant with an abnormality;

(4) consanguinity/incest;

(5) parent is a known carrier or has a family history of a genetic condition;

(6) parent was exposed to a known or suspected reproductive hazard;

(7) previous fetal demise, stillbirth, or neonatal death involving known/suspected abnormalities;

(8) history of recurrent pregnancy loss; or

(9) parent(s) are in an ethnic or racial group associated with an increased risk for specific genetic conditions.

(b) These services may be provided in an office or outpatient setting.

**MEDICAL PROVIDERS-FEE FOR SERVICE
LACTATION CONSULTANTS SPECIFIC**

OAC 317:30-5-230

317:30-5-230. General Information

The primary focus of this service is member-specific support and education regarding breastfeeding, addressing particular issues, and/or managing lactation crisis.

**MEDICAL PROVIDERS-FEE FOR SERVICE
LACTATION CONSULTANTS SPECIFIC**

OAC 317:30-5-231

317:30-5-231. Eligible Providers

Eligible providers must be an International Board Certified Lactation Consultant, Registered Lactation Consultant (IBCLC,RLC). IBCLC, RLC must have a current contract on file with the Oklahoma Health Care Authority.

317:30-5-232. Coverage

Lactation Consultant services are covered for pregnant women and women up to 60 days postpartum. SoonerCare members may self-refer or be referred by any provider. Reasons for lactation services include but are not limited to the following:

- (1) prenatal education/training for first time mothers;
- (2) women who have not previously breastfed, have a history of breastfeeding difficulty, have identified risk factors for breastfeeding difficulty or lactation insufficiency (e.g., history of breast surgery, infertility, hormonal imbalance, diabetes, obesity);
- (3) women expecting an infant with risk factors for ineffective breastfeeding (e.g., preterm, multiples, congenital birth defects);
- (4) latch-on difficulties;
- (5) low milk supply;
- (6) breastfeeding a premature baby (36 weeks or less gestation);
- (7) breastfeeding multiples; and
- (8) a baby with special needs (e.g., Down Syndrome, cleft lip/or palate).

317:30-5-233. Limitations

(a) Services billed by a contracted IBCLC/RLC are only covered when performed in the IBCLC's/RLC's office setting, patient's home, or other confidential outpatient setting. Payment for inpatient services provided by a Lactation Consultant is included in the hospital's per diem rate.

(b) No separate reimbursement will be made to a facility.

(c) Services are not to duplicate any basic breastfeeding education/training a member may have received through another program such as WIC or the Children's First Program and services must be problem focused.

(d) Services provided by a contracted IBCLC/RLC must be provided face-to-face and in an individual setting.

(e) Reimbursement is limited to not more than 6 sessions per pregnancy and must be objectively documented as medically necessary.

317:30-5-234. Reimbursement

IBCLCs/RLCs who are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

317:30-5-235. Documentation

All services must be documented in the member's medical record.
All prenatal and postpartum lactation sessions must, at a minimum,
include the following:

- (1) date of service;
- (2) start and stop time for each session;
- (3) documentation of services provided;
- (4) practitioner's signature; and
- (5) recommendation and plan of care.

317:35-5-8. Determining categorical relationship for the Family Planning Waiver Program

All uninsured women and men ages 19 and older, who have not undergone a sterilization procedure, regardless of pregnancy or paternity history, with family income at or below 185% of the federal poverty level and who are otherwise ineligible for SoonerCare benefits are categorically related to the Family Planning Waiver Program. If eligible for SoonerCare benefits, the individual can choose to enroll only in the Family Planning Waiver Program with the option of applying for SoonerCare at any time.

317:35-6-15. Application for SoonerCare Health Benefits for Pregnant Women and Families with Children; forms

(a) **Application.** An application for categorically needy pregnant women and families with children consists of the Health Benefits Application. The application form is signed by the individual, parent, spouse, guardian, or someone else acting on the individual's behalf. A categorically needy individual does not have to have received a medical service nor expect to receive one to be certified for Health Benefits for Pregnant Women and Families with Children.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility, Health Department, or in the county OKDHS office. A face to face interview is not required. Applications may be mailed or faxed to the local county OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for health benefits, the physician or facility may forward an application to the OKDHS county office of the patient's residence for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application.

(2) Form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the Health Benefits Application form or Form 08MA005E constitutes an application for SoonerCare.

(4) If Form 08MA005E is received and an application cannot be completed, receipt of Form 08MA005E constitutes an application which must be registered and subsequently denied. The member and provider are notified by computer-generated notice.

(b) **Date of application.** When application is made in the county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application or Form 08MA005E is stamped into the county office. When an application is faxed, the application date is the date the fax is received. When a request for Health Benefits is first made by an oral request to the county office, and the application form is signed later, the date of the

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oral request is entered in "red" on the application form above the date the form is signed. The date of the oral request is the date of application to be shown on the computer form. When Form 08MA005E is received in the county office prior to the completion of the application form, the date that Form 08MA005E is received is considered as the date of application and must be registered as an application. Certain providers may take applications and then forward them to the OKDHS county office for Health Benefits eligibility determination. Under this circumstance, the application date is the date the member signed the application form for the provider.

317:35-7-15. Application for Medical Services; forms

(a) **Application.** An application for Medical Services consists of the Medical Assistance Application. The application form is signed by the individual, parent, spouse, guardian or someone else acting on the individual's behalf. A categorically needy individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility or in the county OKDHS office. A face to face interview is not required. Applications may be mailed or faxed to the local county OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for health benefits, the physician or facility may forward an application or 08MA005E to the OKDHS county office of the patient's residence for processing.

If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application.

(2) Form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the Medical Assistance Application form or Form 08MA005E constitutes an application for SoonerCare.

(4) If Form 08MA005E is received and an application cannot be completed, receipt of Form 08MA005E constitutes an application which must be registered and subsequently denied. The member and provider are notified by computer-generated notice. ■ 1

(5) If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the Medical Assistance Application form. ■ 2

(b) **Date of application.** When application is made in the county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application or Form 08MA005E is stamped into the county office. When an application is faxed, the application date is the date the fax is received. When a request for SoonerCare is first made by an oral request to the county office, and the application form is signed later, the date of the oral request is entered in "red" on the application form above the date the form is signed. The date of the oral request is the date

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of application to be shown on the computer form. When Form 08MA005E is received in the county office prior to the completion of the application form, the date that Form 08MA005E is received is considered as the date of application and must be registered as an application. Certain providers may take applications and then forward them to the OKDHS county office for SoonerCare eligibility determination. Under this circumstance, the application date is the date the member signed the application form for the provider.

INSTRUCTIONS TO STAFF

1. All conditions of eligibility must be verified and documented in the case record.
2. If an individual is certified for a money payment and received medical services in any of the three months prior to the month of application, if the worker chooses to set up a separate case for those months, a copy of the application must be filed in that case.

317:35-7-48. Eligibility for the Family Planning Waiver Program

(a) Women and men ages 19 and above are eligible to receive family planning services if they meet all of the conditions of eligibility in paragraphs (1), (2), (3), and (4) of this Subsection. This is regardless of pregnancy or paternity history and includes women who gain eligibility for family planning services due to a pregnancy, but whose eligibility ends 60 days postpartum.

(1) The countable income is at or below 185% of the federal poverty level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is \$240 per each full-time or part-time employed member of the benefit group. Deductions for work related expenses for self-employed individuals are found at OAC 317:35-10-26(b)(1).

(2) Individuals eligible for SoonerCare can choose to enroll only in the Family Planning Waiver Program with the option of applying for SoonerCare at any time.

(3) The individual is uninsured. Persons who have Medicare or creditable health insurance coverage are not eligible for the Family Planning Waiver program. A stand alone policy such as dental, vision or pharmacy is not considered creditable health insurance coverage.

(4) The individual has not undergone a sterilization procedure.

(b) All health insurance is listed on the OKDHS computer system in order for OHCA Third Party Liability Unit to verify insurance coverage.

(c) Income for the Family Planning Waiver Program does not require verification, unless questionable. If the income is questionable the worker must verify the income.

(d) There is not an asset test for Family Planning Waiver Program.

317:45-9-1. Employee eligibility requirements

(a) Employee premium assistance applications are made with the TPA.
(b) The TPA electronically submits the application to the Oklahoma Department of Human Services (OKDHS) for a determination of eligibility. The eligibility determination is processed within 30 days from the date the application is received by the TPA. The employee is notified in writing of the eligibility decision.

(c) All O-EPIC eligible employees described in this Section are enrolled in their Employer's QHP. Employees eligible for O-EPIC must:

- (1) have a countable household income at or below 200% of the Federal Poverty Level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is \$240 per each full-time or part-time employed member;
- (2) be a US citizen or alien as described in OAC 317:35-5-25;
- (3) be Oklahoma residents;
- (4) provide his/her social security number;
- (5) not be currently enrolled in, or have an open application for, SoonerCare/Medicare;
- (6) be employed with a qualified employer at a business location in Oklahoma;
- (7) be age 19 through age 64;
- (8) be eligible for enrollment in the employer's Qualified Health Plan;
- (9) be working for primary employer(s) who all meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
- (10) select one of the Qualified Health Plans the employer is offering.

(d) An employee's spouse is eligible for O-EPIC if:

- (1) the employer's health plan includes coverage for spouses;
- (2) the employee is eligible for O-EPIC;
- (3) if employed, the spouse's primary employer(s) meets employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
- (4) the spouse is enrolled in the same health plan as the employee.

(e) If an employee or spouse is eligible for multiple O-EPIC Qualified Health Plans, each may receive a subsidy under only one health plan.

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

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

- (1) services that the member's PCP or O-EPIC does not consider medically necessary;
- (2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
- (3) organ and tissue transplant services;
- (4) treatment of obesity;
- (5) procedures, services and supplies related to sex transformation;
- (6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
- (7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
- (8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
- (9) experimental procedures, drugs or treatments;
- (10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) except for pregnant women and as covered in OAC 317:30-5-696;
- (11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
- (12) physical medicine including speech, physical, occupational, chiropractic, acupuncture and osteopathic manipulation therapy;
- (13) hearing services;
- (14) transportation [emergent or non-emergent (air or ground)];
- (15) rehabilitation (inpatient);
- (16) cardiac rehabilitation;
- (17) allergy testing and treatment;
- (18) home health care with the exception of medications, intravenous (IV) therapy, supplies;
- (19) hospice regardless of location;
- (20) Temporomandibular Joint Dysfunction (TMD) (TMJ);
- (21) genetic counseling;
- (22) fertility evaluation/treatment/and services;
- (23) sterilization reversal;
- (24) Christian Science Nurse;
- (25) Christian Science Practitioner;
- (26) skilled nursing facility;
- (27) longterm care;
- (28) stand by services;
- (29) thermograms;

- (30) abortions (for exceptions, refer to OAC 317:30-5-6);
- (31) services of a Lactation Consultant;
- (32) services of a Maternal and Infant Health Licensed Clinical Social Worker; and
- (33) enhanced services for medically high risk pregnancies as found in OAC 317:30-5-22.1.

317:45-11-20. O-EPIC Individual Plan eligibility requirements

(a) Employees not eligible for participating in an employer's Qualified Health Plan (QHP), employees of non-participating employers, self-employed, unemployed seeking work, and workers with a disability may apply for the O-EPIC Individual Plan. Applicants cannot obtain O-EPIC IP coverage if they are eligible for O-EPIC PA.

(b) Applications may be found on the World Wide Web or may be requested by calling the O-EPIC helpline. Completed applications are submitted to the TPA.

(c) The TPA electronically submits the application to the Oklahoma Department of Human Services (OKDHS) for a determination of eligibility. The eligibility determination is processed within 30 days from the date the complete application is received by the TPA. The applicant is notified in writing of the eligibility decision.

(d) In order to be eligible for the IP, the applicant must:

- (1) choose a valid PCP according to the guidelines listed in OAC 317:45-11-22, at the time they make application;
- (2) be a US citizen or alien as described in OAC 317:35-5-25;
- (3) be an Oklahoma resident;
- (4) provide his/her social security number;
- (5) not be currently enrolled in, or have an open application for, SoonerCare/Medicare;
- (6) be age 19 through 64; and
- (7) make premium payments by the due date on the invoice.

(e) If employed and working for an approved O-EPIC employer who offers a QHP, the applicant must meet the requirements in subsection (d) of this Section and:

- (1) have household income at or below 200% of the Federal Poverty Level.
- (2) be ineligible for participation in their employer's QHP due to number of hours worked.
- (3) have received notification from O-EPIC indicating their employer has applied for O-EPIC and has been approved.

(f) If employed and working for an employer who doesn't offer a QHP, the applicant must meet the requirements in subsection (d) of this Section and:

- (1) have a countable household income at or below 200% of the Federal Poverty Level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is \$240 per each full-time or part-time employed member; and
- (2) have received notification from O-EPIC indicating their employer has applied and has been approved with the attestation

that they are not offering a QHP.

(g) If self-employed, the applicant must meet the requirements in subsection (d) of this Section and:

(1) must have household income at or below 200% of the Federal Poverty Level;

(2) verify self-employment by providing the most recent federal tax return with all supporting schedules and copies of all 1099 forms; and

(3) verify current income by providing appropriate supporting documentation.

(h) If unemployed seeking work, the applicant must meet the requirements in subsection (d) of this Section and:

(1) must have household income at or below 200% of the Federal Poverty Level; and

(2) verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:

(A) OESC eligibility letter,

(B) OESC weekly unemployment payment statement, or

(C) bank statement showing state treasurer deposit.

(i) If working with a disability, the applicant must meet the requirements in subsection (d) of this Section and:

(1) must have household income at or below 200% of the Federal Poverty Level based on a family size of one; and

(2) verify eligibility by providing a copy of their:

(A) ticket to work, or

(B) ticket to work offer letter.