TO: STAFF LISTED

SUBJECT: MANUAL MATERIAL
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
OAC 317:30-3-59, 30-3-60, 30-5-2, and 30-5-60.

EXPLANATION: General coverage rules are revised to make OHCA rules consistent with reimbursement practices and make coverage rules more consistent throughout policy. Specifically, rules are revised to be consistent with the Centers for Medicare and Medicaid Services (CMS) regarding the elimination of office and inpatient consultation codes. Additional revisions include general policy cleanup as it relates to these sections.

INSTRUCTIONS FOR FILING OF REVISED MANUAL MATERIAL

Forms or appendices which have an OAC number in the header should be filed at the back of the identified Chapter. (For example, OAC 317:30 means Chapter 30.) Any form or appendix without an OAC number should be maintained in the Forms/Appendix manuals as always.

Any material that has OHCA in place of 317 should be placed in the Chapter that it identifies. To help with placement make dividers for each Chapter as follows: (1) Chapter number with the heading [Example: 30. Medical Providers - Fee for Service]; (2) Appendices; and (3) [this will not apply to all Chapters] OHCA: [Chapter number]. The title in the header is the Chapter heading, the title in the footer is the Subchapter heading.

Should you have questions or need assistance please contact Demetria Morrison 405-522-7641, Health Policy.

REMOVE: INSERT:

<table>
<thead>
<tr>
<th>REMOVE</th>
<th>INSERT</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-3-59, pages 1-2</td>
<td>30-3-59, pages 1-2, Revised 06-25-11</td>
</tr>
<tr>
<td>30-3-60, pages 1-2</td>
<td>30-3-60, pages 1-2, Revised 06-25-11</td>
</tr>
<tr>
<td>30-5-2, pages 1-9</td>
<td>30-5-2, pages 1-9, Revised 06-25-11</td>
</tr>
<tr>
<td>30-5-9, pages 1-3</td>
<td>30-5-9, pages 1-3, Revised 06-25-11</td>
</tr>
</tbody>
</table>

Tywanda Cox, Director
Health Policy

WF# 10-11
317:30-3-59. General program exclusions - adults

The following are excluded from SoonerCare coverage for adults:

1. Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
2. Services or any expense incurred for cosmetic surgery.
3. Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
4. Refractions and visual aids.
5. Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
6. Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
8. Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
9. Medical services considered experimental or investigational.
10. Services of a Certified Surgical Assistant.
11. Services of a Chiropractor. Payment is made for Chiropractor services on Crossover claims for coinsurance and/or deductible only.
12. Services of an independent licensed Physical and/or Occupational Therapist.
13. Services of a Psychologist.
14. Services of an independent licensed Speech and Hearing Therapist.
15. Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.
16. Payment for more than two nursing facility visits per month.
17. More than one inpatient visit per day per physician.
18. Payment for removal of benign skin lesions unless medically necessary.
19. Physician services which are administrative in nature and not a direct service to the member including such items as
quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

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

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

(22) Mileage.

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

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


(26) Fertility treatment.

(27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
317:30-3-60. General program exclusions - children
(a) The following are excluded from SoonerCare coverage for children:
   (1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
   (2) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.
   (3) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
   (4) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
   (5) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
   (6) Non-therapeutic hysterectomies.
   (7) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (See OAC 317:30-5-6 or 317:30-5-50).
   (8) Medical services considered experimental or investigational.
   (9) Services of a Certified Surgical Assistant.
   (10) Services of a Chiropractor.
   (11) More than one inpatient visit per day per physician.
   (12) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
   (13) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
   (14) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
   (15) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
   (16) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
   (17) Mileage.
(18) A routine hospital visit on date of discharge unless the member expired.

(b) Not withstanding the exclusions listed in (1)-(18) of subsection (a), the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) provides for coverage of needed medical services normally outside the scope of the medical program when performed in connection with an EPSDT screening and prior authorized.
317:30-5-2. General coverage by category

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

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.
(B) Inpatient psychotherapy by a physician.
(C) Inpatient psychological testing by a physician.
(D) One inpatient visit per day, per physician.
(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.
(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies or opportunistic infections.
(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.
(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".
(I) Diagnostic x-ray and laboratory services.
(J) Mammography screening and additional follow-up mammograms.
(K) Obstetrical care.
(L) Pacemakers and prostheses inserted during the course of a surgical procedure.
(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by
OHCA. A copy of the authorization, OKDHS form 08MA016E, Authorization for Examination and Billing, must accompany the claim.

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

(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.

(P) Genetic counseling.

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

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

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

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

   (i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;
   (ii) Board certification or completion of an accredited residency program in the fellowship specialty area;
   (iii) Hold unrestricted license to practice medicine in Oklahoma;
   (iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;
   (v) Seeing members without supervision;
   (vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;
   (vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number.
(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.

(U) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met:

(i) Attending physician performs chart review and signs off on the billed encounter;
(ii) Attending physician is present in the clinic/or hospital setting and available for consultation;
(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

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

(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;
(ii) The contact must be documented in the medical record.

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

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

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

(i) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.
(ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.
(iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.
(iv) Procedures considered experimental or investigational are not covered.
(Z) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.
   (i) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure.
   (ii) Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.
(AA) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.
(BB) Ventilator equipment.
(CC) Home dialysis equipment and supplies.
xDD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.
(EE) Smoking and Tobacco Use Cessation Counseling for treatment of individuals using tobacco.
   (i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:
      (I) Asking the member to describe their smoking use;
      (II) Advising the member to quit;
      (III) Assessing the willingness of the member to quit;
      (IV) Assisting the member with referrals and plans to quit; and
      (V) Arranging for follow-up.
   (ii) Up to eight sessions are covered per year per individual.
   (iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, and Oklahoma State Health Department and FQHC nursing staff. It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP care coordination payments, evaluation and management codes, or
other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

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

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

(2) General coverage exclusions include the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
(B) Services or any expense incurred for cosmetic surgery.
(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
(D) Refractions and visual aids.
(E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(H) Non-therapeutic hysterectomies.
(I) Medical services considered experimental or investigational.
(J) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.
(K) Payment for more than two nursing facility visits per month.
(L) More than one inpatient visit per day per physician.
(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

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

(Q) Speech and Hearing services.

(R) Mileage.

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

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

(U) Inpatient chemical dependency treatment.

(V) Fertility treatment.

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

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

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

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

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

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

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

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

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

(6) **Child abuse/neglect findings.** Instances of child abuse
and/or neglect discovered through screenings and regular exams
are to be reported in accordance with State Law. Section 7103
of Title 10 of the Oklahoma Statutes mandates reporting
suspected abuse or neglect to the Oklahoma Department of Human
Services. Section 7104 of Title 10 of the Oklahoma Statutes
further requires reporting of criminally injurious conduct to
the nearest law enforcement agency.

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

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

(B) Services or any expense incurred for cosmetic surgery
unless the physician certifies the procedure emotionally
necessary.
(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
(D) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(F) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(G) Non-therapeutic hysterectomies.
(H) Medical Services considered experimental or investigational.
(I) More than one inpatient visit per day per physician.
(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
(K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Mileage.
(P) A routine hospital visit on date of discharge unless the member expired.

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

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

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for the denial.
317:30-5-9. Medical services
(a) Use of medical modifiers. The Physicians' Current Procedural Terminology (CPT) and the second level HCPCS provide for 2-digit medical modifiers to further describe medical services. Modifiers are used when appropriate.
(b) Covered office services.
   (1) Payment is made for four office visits (or home) per month per member, for adults (over age 21), regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.
   (2) Visits for the purpose of family planning are excluded from the four per month limitation.
   (3) Payment is allowed for the insertion and/or implantation of contraceptive devices in addition to the office visit.
   (4) Separate payment will be made for the following supplies when furnished during a physician's office visit.
      (A) Casting materials
      (B) Dressing for burns
      (C) Contraceptive devices
      (D) IV Fluids
   (5) Payment is made for routine physical exams only as prior authorized by the OKDHS and are not counted as an office visit.
   (6) Medically necessary office lab and X-rays are covered.
   (7) Hearing exams by physician for members between the ages of 21 and 65 are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.
   (8) Hearing aid evaluations are covered for members under 21 years of age.
   (9) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.
   (10) Payment is made for both an office visit and an injection of joints performed during the visit if the joint injection code does not have a global coverage designation.
   (11) Payment is made for an office visit in addition to allergy testing.
   (12) Separate payment is made for antigen.
   (13) Eye exams are covered for members between ages 21 and 65 for medical diagnosis only.
   (14) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.
   (15) Separate payment is made for the following specimen collections:
      (A) Catheterization for collection of specimen; and
      (B) Routine Venipuncture.
(16) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.

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

(c) Non-covered office services.

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

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

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

(4) Additional payment will not be made for mileage.

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

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

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

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

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

(d) Covered inpatient medical services.

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

(2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved.

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

(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day.

(e) Non-covered inpatient medical services.

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

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

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

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

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

(f) Other medical services.

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

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

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

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