METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

II. GENERAL REIMBURSEMENT POLICY (continued)

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

G. New providers entering the Medicaid program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG PPS payment method of the statewide median rate for per diem methods.

H. All hospitals which meet the criteria in Section VI of this plan will be eligible for graduate medical education payments.

I. All hospitals which meet the criteria in Section VIII of this plan will be eligible for a disproportionate share adjustment.

J. Medical assistance will not be paid for PPCs as described on Supplement 1 to Attachment 4.19-A ~~Effective for services provided on or after February 1, 2010, approved inpatient hospital rates will not be paid for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.~~

~~K. Effective for services provided on or after April 1, 2010, approved inpatient hospital rates will not be paid for Hospital Acquired Conditions (HACs) that are identified as non-payment by Medicare.~~

III. PAYMENT METHODOLOGY FOR FREESTANDING REHABILITATION, AND FREESTANDING PSYCHIATRIC HOSPITALS

Effective October 1, 2005, reimbursement to freestanding rehabilitation and psychiatric hospitals for inpatient hospital services is paid on a prospective per diem level of care payment system. There are two distinct payment components under this system. Total per diem reimbursement will equal the sum of:

Level of care operating per diem
+
Fixed capital per diem

A. Level of Care Operating Per Diem Rates

1.The level of care per diem rates are payments for allowable operating costs and movable capital costs as defined in HCFA publications 15-1 for Medicare cost reporting purposes and reported on the HCFA 2552. No return on equity is included in the per diem rate. There are eight levels of care. For each level of care category, the payment rate was established based on the statewide rate in effect on September 30, 2005, for providing services within that level of care.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19-A

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Outpatient Hospital Reimbursement

General

These provisions apply to all hospitals approved for participation in the Oklahoma SoonerCare program. In no case can reimbursement for outpatient hospital services exceed the upper payment limits as defined under 42 CFR 447.321. Laboratory services will not exceed maximum levels established by Medicare. Clinical diagnostic lab services (not laboratory services) do not exceed the maximum levels.

Medical assistance will not be paid for PPCs as described on Supplement 2 to Attachment 4.19-B ~~Effective February 1, 2010, payment for outpatient services will not be made for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.~~

A. Emergency Room Services

Payment will be made based on Medicare APC groups for Type A and Type B Emergency Departments.

B. Outpatient Surgery

1. Payment will be made for certain outpatient surgical procedures provided in hospitals based on the Medicare Ambulatory Surgery Center (ASC) facility services payment system unless otherwise denoted in this section. The surgical procedures are classified into payment groups based on Current Procedural Terminology (CPT). All procedures within the same payment group are paid at a single payment rate. For purposes of specifying the services covered by the facility rate, the OHCA hereby adopts and incorporates herein by reference the Medicare ASC procedures.

1a. Effective on or after January 1, 2018, certain outpatient surgical services provided in an outpatient hospital are reimbursed on a cost basis. Dental and Level 4 ear, nose, and throat (ENT) surgical procedures are classified into a payment group based on CPT codes. A facility specific outpatient cost to charge ratio (CCR) from the hospital Medicare cost report is used to determine average cost per unit by facility, then in total. Each individual procedure code for the dental (D9999) and Level 4 ENT (various codes) will be paid the same cost based single rate set based on statewide hospital costs. These rates will be recalculated annually using the most recent available cost report data from HCRIS.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for physicians' services (includes medical and remedial care and services)

Payment for physician's services, radiology services and services rendered by other practitioners under the scope of their practice under State law, are covered under the Agency fee schedule. The payment amount for each service paid for under the fee schedule is the product of a uniform relative value unit (RVU) for each service and the Medicare conversion factor (CF). The Medicare CF converts the relative values into payment amounts. The general formula for calculating the fee schedule can be expressed as:

RVU x CF = Rate

EPSDT screenings and eye exams by optometrists have been incorporated into the fee schedule.

Medical assistance will not be paid for PPCs as described on Supplement 2 to Attachment 4.19-B ~~Effective February 1, 2010, payment will not be made to physicians or other practitioners for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.~~

Vaccines are paid the equivalent to Medicare Part B, ASP + 6%. When ASP is not available, an equivalent price is calculated using Wholesale Acquisition Cost (WAC). If no Medicare, ASP, or WAC pricing is available, then the price will be calculated based on invoice cost. No payment will be made to physicians or other practitioners for vaccines that were received through the Vaccine for Children's program.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Anesthesiologists *(continued)*

Time (in Minutes)	Unit(s) Billed
1-15	1.0
16-30	2.0
31-45	3.0
46-60	4.0
61-75	5.0
76-90	6.0
91-105	7.0
106-120	8.0
Etc.	

Effective January 1, 2008, Anesthesia Healthcare Common Procedure Coding System (HCPC) modifiers must be reported for each anesthesia service billed and will determine the rate of reimbursement to each provider for anesthesia services. The modifiers are as follows:

2014 Published HCPC Modifier	Description	Payment Rate
AA	Anesthesia services performed personally by Anesthesiologist.	100%
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	Current Flat Rate; no time units
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	50%
QX	CRNA or AA service: with medical direction by a physician	50%
QY	Anesthesiologist medically directs one CRNA or AA	50%
QZ	CRNA or AA services	80%

Certified Registered Nurse Anesthetists (CRNA)

Modifiers must be reported for each anesthesia service billed and will determine the rate of reimbursement to each provider for anesthesia services. Payment is made to CRNAs at a rate of 80 percent of the allowable for physicians for anesthesia services without medical direction and at a rate of 50 percent of the allowable when medically directed.

Anesthesiologist Assistants

Modifiers must be reported for each anesthesia service billed and will determine the rate of reimbursement to each provider for anesthesia services. Payment is made to Anesthesiologist Assistants at a rate of 80 percent of the allowable for physicians for anesthesia services without medical direction and at a rate of 50 percent of the allowable when medically directed.

Medical assistance will not be paid for PPCs as described on Supplement 2 to Attachment 4.19-B ~~Effective February 1, 2010, payment will not be made to anesthesiologists, CRNAs or AAs for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.~~

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Physician Assistants

Payment is made to physician assistants at 20 percent of the surgery allowable for physicians when service is assisting a surgeon at surgery.

All other services are reimbursed at 100 percent of the physician allowable.

Medical assistance will not be paid for PPCs as described on Supplement 2 to Attachment 4.19-B ~~Effective February 1, 2010, payment will not be made to physician assistants for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.~~

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19B

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan: