Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's Proposed Changes Blog.

OHCA COMMENT DUE DATE: March 3, 2023

The proposed policy changes are Permanent Rules. The proposed policy changes were presented at the January 3, 2023 Tribal Consultation. The proposed rule changes will be presented at a Public Hearing on March 7, 2023. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on March 2, 2023 and the OHCA Board of Directors on March 22, 2023.

SUMMARY:
Outdated/Obsolete Policy Language Cleanup — The proposed rule changes will amend language to remove obsolete references. Additional revisions will combine sections of policy to remove the overabundant number of sections that are currently in Title 317.

LEGAL AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; Oklahoma Executive Order 2020-03

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 22-30

A. Brief description of the purpose of the rule:

The proposed rule changes will amend language to remove obsolete references. Additional revisions will combine sections of policy to remove the overabundant number of sections that are currently in Title 317. These changes are necessary to comply with Oklahoma Executive Order 2020-03.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

No classes of persons will be affected by this proposed rule since the language revisions clean up policy, removes duplicative content, and does not change the program's operations.

C. A description of the classes of persons who will benefit from the proposed rule:

No classes of persons will benefit from the combining of the sections.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The proposed rule changes are budget neutral.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there are no other legal methods to achieve the purpose of the proposed rule changes. Measures included a formal public comment period and tribal consultation.

I. A determination of the effect of the proposed rule on the public health, safety, and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety, and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule changes should not have any effect on the public health, safety, or environment. The proposed rule changes are not designed to reduce significant risks to the public health, safety, or environment.

J. A determination of any detrimental effect on the public health, safety, and environment if the

proposed rule is not implemented:

The agency does not anticipate any detrimental effect on the public health, safety, or environment if the proposed rule changes are not implemented.

K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared: December 30, 2022

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-3.1. Medicaid Income Deferral Program [REVOKED]

~~(a) The Medicaid Income Deferral Program is a program that enables physician corporations, as defined in Title 59 of the Oklahoma Statutes, to voluntarily defer income that is paid to the corporation by the Single State Medicaid Agency.~~

~~(b) The voluntary income deferral by physician corporations (medical doctors, osteopathic physicians, dentists, surgeons, podiatrists, chiropractors, optometrists, and ophthalmologists) shall be subject to any federal provisions imposed by the Internal Revenue Code, Title 26 of the United States Code. The Health Care Authority may adopt a Plan which provides for the investment of deferral amounts in life insurance or annuity contracts which offer a choice of underlying investment options. The Plan shall provide that each physician corporation exercise those options independently from among choices offered by such contracts. Contract issuing companies shall be limited to companies which are licensed to do business in the state of Oklahoma.~~

~~(c) To be eligible for this program a physician corporation must have an existing contract with the Oklahoma Health Care Authority and the corporation must perform that contract for the term of the agreement. If a physician corporation fails to fulfill its service obligations under the contract, all deferral amount assets held for the benefit of that corporation shall be forfeited.~~

~~(d) No physician corporation shall be permitted to participate in the Plan without having prior independent tax and legal advice to do so.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-70.4. Federal/State cost share-optional program [REVOKED]

~~The Medicaid prescription drug program is an optional program under Title XIX of the Social Security Act. The program is administered through a partnership between federal and state agencies. Program costs are shared between the federal and state government at variable rates depending on the economic status of the State.~~

317:30-5-80. National drug code [REVOKED}

~~All products billed must have a valid National Drug Code. Products which do not have an NDC code are not compensable.~~

317:30-5-86.2. Case management [REVOKED]

~~OHCA contracts with a designated agent to evaluate and manage the medication therapies of the individuals who comprise the top percentage of drug utilization. Clinical pharmacists will do case management based on the clinical needs of each patient.~~

PART 6. INPATIENT PSYCHIATRIC AND SUBSTANCE USE DISORDER SERVICES

317:30-5-95.43. Residential substance use disorder treatment

(a) **Purpose**. The purpose of sections OAC 317:30-5-95.43 - 317:30-5-95.49 is to establish the procedures and requirements for residential treatment facilities providing SUD treatment services.

(b) **Definitions**. The following words and terms, when used in the aforementioned sections, shall have the following meanings unless the context clearly indicates otherwise.

(1) **"ASAM"** means the American Society of Addiction Medicine.

(2) **"ASAM criteria"** means the most recent edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

(3) **"ASAM levels of care"** means the different options for treatment as described below and in the current edition of the ASAM criteria that vary according to the intensity of the services offered. Each treatment option is a level of care.

(A) **"ASAM level 3"** means residential and inpatient services and encompasses ASAM levels 3.1, 3.3, 3.5 and 3.7.

(B) **"ASAM level 3.1"** means clinically managed low-intensity residential services for adolescents and adults. This level of care typically provides at least five (5) hours of clinical services a week and provides a twenty-four (24) hour living support and structure with trained personnel. The corresponding service description for this level of care is halfway house services.

(C) **"ASAM level 3.3"** means clinically managed population-specific high-intensity residential services. This level of care is for adults only and typically offers twenty-four (24) hour care with trained personnel and is designed to accommodate individuals with cognitive or other impairments. The corresponding service description for this level of care is residential treatment for adults with co-occurring disorders.

(D) **"ASAM level 3.5"** means clinically managed medium-intensity residential services for adolescents and clinically managed high-intensity residential services for adults. This level of care provides twenty-four (24) hour care and offers a wide range of therapeutic services. The corresponding service descriptions for this level of care are residential treatment and intensive residential treatment.

(E) **"ASAM level 3.7"** means medically monitored high-intensity inpatient services for adolescents and medically monitored intensive inpatient withdrawal management for adults. This level of care provides twenty-four (24) hour nursing care with physician supervision and medication availability. This level of care is appropriate for individuals withdrawing from alcohol or other drugs with subacute biomedical and emotional, behavioral, or cognitive problems severe enough to require inpatient treatment but for whom hospitalization is not necessary. The corresponding service description for this

level of care is medically supervised withdrawal management.

(4) **"Care management services"** means an assessment of a member, development of a care plan, and referral and linkage to SUD community supports and community-based or lower level of care services to promote continued recovery after the individual discharges from the treatment facility.

(5) **"Co-occurring disorder (COD)"** means any combination of mental health symptoms and SUD symptoms or diagnoses that affect a member and are typically determined by the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(6) **"DSM"** means the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

(7) "**ODMHSAS**" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

(8) **"Per diem"** means an all-inclusive rate for covered SUD treatment services provided each day during a facility stay.

~~(8)~~(9) **"Rehabilitation services"** means face-to-face individual or group services provided by qualified staff to develop skills necessary to perform activities of daily living and successful integration into community life. Rehabilitation services for substance use disorders are also referred to as skill development services.

~~(9)~~(10) "**Service plan**" means the document used during the process by which an LBHP or a licensure candidate and the member together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.

~~(10)~~(11) "**Substance use disorder (SUD)"** means alcohol or drug dependence, or psychoactive SUD as defined by the most recent DSM criteria.

~~(11)~~(12) "**Therapeutic services"** means professional services during which members engage in identifying, addressing and/or resolving issues identified in the member's service plan.

~~(12)~~(13) **"Treatment hours – residential"** means the structured hours in which a member is involved in receiving professional services to assist in achieving recovery.

317:30-5-95.50. Residential substance use disorder (SUD) – Reimbursement

(a) In order to be eligible for payment, residential treatment providers of SUD treatment services must have an approved provider agreement on file with the OHCA. Through this agreement, the residential provider assures that they are in compliance with all applicable federal and State Medicaid law and regulations, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, and the Oklahoma Medicaid State Plan.

(b) Covered SUD treatment services for adolescents and adults in SUD residential treatment shall be reimbursed utilizing the per diem rates for each level of care. All SUD residential treatment services must be prior authorized by the OHCA or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.

(c) ~~Covered SUD treatment services for adolescents and adults in SUD residential treatment shall be reimbursed utilizing the per diem rates for each level of care.~~ Separate payment may be made for medications, physician services, and treatment services provided to dependent children in accordance with the Oklahoma Medicaid State Plan. Separate payment for such services will follow existing prior authorization requirements, if applicable.

(d) Treatment services for dependent children accompanying a parent to treatment shall be reimbursed on a fee-for-service basis in accordance with the Oklahoma Medicaid State Plan.

Outpatient services rendered to dependent children may be provided by the residential facility if appropriately certified or a separate outpatient provider. Such services shall not duplicate any services provided by the residential provider that are reimbursed through the residential per dime rate.

(e) The following services are excluded from coverage/reimbursement:

(1) Room and board;

(2) Services or components that are not provided to or exclusively for the treatment of the member;

(3) Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a member receiving covered services;

(4) Physician directed services and medications (these services are reimbursed outside of the residential SUD per diem);

(5) Telephone calls or other electronic contacts (not inclusive of telehealth); and

(6) Field trips, social, or physical exercise activity groups.

PART 33. TRANSPORTATION BY AMBULANCE

317:30-5-336.3. Destination and transport outside of locality

(a) Transportation is covered from the point of origin to the Hospital, Critical Access Hospital or Nursing Facility that is capable of providing the required level and type of care for the member.

(b) Ambulance transportation from a hospital with a higher level of care to a hospital with a lower level of care in the locality is covered, provided all other criteria are met and approved by the OHCA.

(c) Non-emergency transportation to the outpatient facilities of a Hospital, free-standing Ambulatory Surgery Center (ASC), Independent Diagnostic Testing Facility (IDTF), Physician's office or other outpatient facility is compensable if the member's condition necessitates ambulance or stretcher transportation and all other conditions are met.

(d) Ambulance Transportation to a Veteran's Administration (VA) Hospital is covered when the trip has not been authorized by the VA.

(e) If ambulance transportation is provided out of the transport locality, the claim must be documented with the reason for the transport outside of the service area.

(f) If it is determined the member was transported out of locality and the closest facility could have cared for the member, payment will be made only for the distance to the nearest medical institution with the appropriate facilities.

(g) Any transportation which begins or ends outside of the Oklahoma geographic border requires prior authorization. The exception to this rule is if transportation begins or ends within one hundred (100) miles of Oklahoma's geographic border, no prior authorization is required.

317:30-5-336.4. Transport outside of locality [REVOKED]

~~(a) If ambulance transportation is provided out of the transport locality, the claim must be documented with the reason for the transport outside of the service area.~~

~~(b) If it is determined the member was transported out of locality and the closest facility could have cared for the member, payment will be made only for the distance to the nearest medical institution with the appropriate facilities.~~

~~(c) Any transportation which begins or ends outside of the Oklahoma geographic border requires prior authorization. The exception to this rule is if transportation begins or ends within 100 miles~~

~~of Oklahoma's geographic border, no prior authorization is required.~~

PART 61. HOME HEALTH AGENCIES

317:30-5-547. Reimbursement and procedure codes

(a) Nursing services and home health aide services are covered services on a per visit basis. Thirty-six (36) visits per calendar year of nursing and/or home health aide services for any member do not require prior authorization; however, any visit surpassing the thirty-sixth (36) visit will require prior authorization and medical review.

(b) Reimbursement for durable medical equipment and supplies will be made using the amount derived from the lesser of the Oklahoma Health Care Authority (OHCA) fee schedule or the provider's usual and customary charge. When a procedure code is not assigned a maximum allowable fee for a unit of service, a fee will be established. Once the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim.

(c) Reimbursement for oxygen and oxygen supplies is as follows:

(1) Payment for oxygen systems (stationary, liquid and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are also considered continuous rental. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pick up the equipment when it is no longer medically necessary.

(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

(4) Physical therapy, occupational therapy, and/or speech pathology and audiology services, are not covered when provided by a home health agency.

(d) All home health services are billed using Healthcare Common Procedure Coding System (HCPCS) codes.

317:30-5-548. Procedure codes [REVOKED]

~~All home health services are billed using Healthcare Common Procedure Coding System (HCPCS) codes.~~