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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 19. CERTIFIED NURSE MIDWIVES

317:30-5-229. Reimbursement

In accordance with the Omnibus Budget Reconciliation Act of 1993, effective October 1, 1993, certified nurse midwife services include maternity services, as well as services outside the maternity cycle within the scope of their practice under state law.

~~(1) Medical verification of pregnancy is required. A written statement from the physician or certified nurse midwife verifying the applicant is pregnant and the expected date of delivery is acceptable. Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is pregnant.~~

~~(2) Newborn charges billed on the mother's person code will be denied.~~

~~(3)~~(1) Providers must use ~~OKDHS Form FSS-NB-1 or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth~~the NODOS/NB1 form (found on the OHCA website at https://oklahoma.gov/ohca/providers/forms.html) for a newborn child delivered by a SoonerCare member. A claim may then be filed for charges for the newborn under the case number and the newborn's name and assigned person code. Newborn charges billed on the mother's person code will be denied.

~~(4)~~(2) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be 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. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider 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 provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

PART 87. BIRTHING CENTERS

317:30-5-890. Eligible providers

Eligible providers are freestanding birthing centers that are not currently licensed as a hospital and meet the following requirements:

(1) Must be accredited by the Commission for the Accreditation of Birth Centers (CABC);

(2) Have a current contract with the Oklahoma Health Care Authority;

(3) Have a current written agreement with a board-certified Obstetrician-Gynecologist (OB-GYN) to provide coverage for consultation, collaboration, or referral services;

(4) Have a current SoonerCare-contracted clinical director who is a physician, certified nurse midwife (CNM), advanced practice registered nurse (APRN), or licensed midwife and is responsible for establishing patient protocols and other functions as defined in requirements for state licensure. This individual may, or may not, be the physician providing individual

patient coverage for consultation, collaborative, or referral service; and

(5) Have a written agreement with a referral hospital which is a Class II hospital. Class II hospital is defined as a facility with 24-hour availability of OB-GYN and capability of performing a C-section within 30 minutes of the decision to operate. The 30-minute timeframe is subject to each hospital's unique circumstance, logistical issues that include, but are not limited to, obtaining informed consent, transporting the patient, and any other potential problems that may arise.

317:30-5-890.1. Definitions

The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

"Birthing center" means a freestanding facility, place, or institution, which is maintained or established primarily for the purpose of providing services of a licensed midwife, certified nurse-midwife, or licensed medical doctor to assist or attend a woman in delivery and birth, and where a woman is scheduled in advance to give birth following a normal, uncomplicated, low-risk pregnancy.

"Certified Midwife" means an individual with a non-nursing graduate degree, educated in midwifery, and certified by the American Midwifery Certification Board (AMCB) who is not a Nurse-Midwife.

"Certified Nurse Midwife" means a person educated in the discipline of nursing and midwifery, certified by the American College of Nurse-Midwives (ACNM), and licensed by the state to engage in the practice of midwifery and as an Advanced Practice Registered Nurse (APRN).

"Certified Professional Midwife" means an individual that graduated from an accredited midwifery program or apprenticeship and is certified by the North American Registry of Midwives (NARM).

"Licensed Midwife" means a Certified Professional Midwife or Certified Midwife who is licensed by the state under 59 O.S. § 3040.6 to engage in the practice of midwifery.

"Low-risk" means a normal, uncomplicated pregnancy with expectation of a normal, uncomplicated birth as defined by generally accepted criteria of maternal and fetal health.

"Newborn" means an infant during the first 28 days following birth.

"Normal" means, as applied to pregnancy, labor, delivery, the postpartum period, and the newborn period, circumstances under which a licensed provider has determined that the member does not have a condition that requires obstetrical intervention.

317:30-5-891. Coverage by category

(a) **Adults and children.** Birthing center services are covered and include admission to the birthing center of low-risk, normal, uncomplicated pregnancies, with an anticipated normal, spontaneous vaginal delivery for the period of labor and delivery.

(b) **Newborn.** Coverage for newborns includes those services within the scope of practice of the provider as defined by state law.

(c) **Individuals eligible for Part B of Medicare.** Birthing center services provided to Medicare eligible recipients should be billed directly to the fiscal agent.

317:30-5-892. Reimbursement

Birthing centers will be reimbursed a facility charge determined by the Ambulatory Payment

Classification (APC) fee schedule maintained by CMS. The facility charge represents payment in full for birthing center services. Separate payment will be made for lab services and midwife or physician obstetrical care, delivery, and postpartum care as appropriate.

317:30-5-893. Billing

Billing for birthing center services will be on UB-04. Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

PART 114. DOULA SERVICES

317:30-5-1217. General coverage

(a) **Covered benefits.**

(1) **Prenatal/postpartum visits.** There is a total of eight (8) visits allowed for the member. The doula must work with the member to determine how best to utilize the benefit to meet the needs of the member.

(2) **Labor and delivery.** There is one (1) visit allowed, regardless of the duration.

(b) **Visit requirements.**

(1) The minimum visit length is sixty (60) minutes.

(2) Visits must be face-to-face.

(A) Prenatal and postpartum visits may be conducted via telehealth.

(B) Labor and delivery services may not be conducted via telehealth.

(c) **Service locations.**

(1) **Prenatal and postpartum.**

(A) Doulas must coordinate directly with the member and their family to determine the most appropriate service location for prenatal and postpartum visits.

(B) Service locations may include the following:

(i) Member's place of residence;

(ii) Doula's office;

(iii) Physician's office;

(iv) Hospital; or

(v) In the community.

(2) **Labor and delivery services.** There is no coverage for home birth(s).

(d) **Referral requirements.** Doula services must be recommended by a physician or other licensed practitioner of the healing arts who is operating within the scope of their practice under State law.

(1) The following providers may recommend doula services:

(A) Obstetricians;

(B) Certified Nurse ~~Midwifes~~Midwives;

(C) Physicians;

(D) Physician Assistants;~~ or~~

(E) ~~Certified Nurse Practitioners.~~Advanced Practice Registered Nurses; or

(F) Licensed Midwives.

(2) The SoonerCare Referral Form must be completed and submitted, noting the recommendation for doula services.

(e) **Prior authorization (PA) requirements.**

(1) A PA is not required to access the standard doula benefit package.

(2) A PA may be submitted, for members with extenuating medical circumstances, if there is need for additional visits beyond the eight (8) prenatal/postpartum visits.

(f) **Medical records requirements.** The medical record must include, but is not limited to, the following:

(1) Date of service;

(2) Person(s) to whom services were rendered;

(3) Start and stop time for the service(s);

(4) Specific services performed by the doula on behalf of the member;

(5) Member/family response to the service;

(6) Any new needs identified during the service; and

(7) Original signature of the doula, including the credentials of the doula.

(g) **Auditing review**. All doula services are subject to post-payment reviews and audits by the OHCA.

(h) **Reimbursement.**

(1) All doula services, that are outlined in Part 114 of this Chapter, are reimbursed per the methodology established in the Oklahoma Medicaid State Plan.

(2) There are no allotted incentive payments.

PART 116. LICENSED MIDWIVES

317:30-5-1235. Eligible Providers

Eligible Providers shall:

(1) Have and maintain one of the following midwifery certifications;

(A) Certified Midwife certification issued by the American Midwifery Certification Board (AMCB) or;

(B) Certified Professional Midwife issued by the North American Registry of Midwives (NARM).

(2) Have and maintain a current license by the Oklahoma State Department of Health as described in Section 3040.6 of Title 59 of Oklahoma Statutes and OAC 310:395-7-2; and

(3) Have a current contract with the Oklahoma Health Care Authority (OHCA).

317:30-5-1236. Covered Services

(a) **Adults and children**. OHCA covers medical services (as described in OAC 317:30-5, Part 1, Physicians) provided in a birthing center by a licensed midwife when rendered within their licensure and scope of practice as defined by state law and regulations. Coverage includes obstetrical care such as antepartum care, delivery, postpartum care, and care of the normal newborn.

(b) **Newborns**. OHCA covers medical services for newborns (as described in OAC 317:30-5, Part 1, Physicians) provided in a birthing center by a licensed midwife when rendered within their licensure and scope of practice as defined by state law and regulations. Services are covered for the newborn during the first six (6) weeks following birth, unless care is transferred to a physician or advanced practice registered nurse specializing in the care of infants and children.

(c) **Limitations**. Medical services rendered by licensed midwives are subject to the same limitations described in OAC 317:30-5, Part 1, Physicians. There is no coverage for home births.

317:30-5-1237. Reimbursement

(a) **Payment**. Payment for covered services (as described in OAC 317:30-5-1226) to eligible providers (as described in OAC 317:30-5-1225) shall be made when the same service would have been covered if ordered or performed by a physician. Payment to licensed midwives is made at 80% of the physician fee schedule for the rendered service. Payment for lab and imaging services ordered by licensed midwives is made at 100% of the physician fee schedule.

(b) **Billing**.

(1) **Adults and children**. Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be 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. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider 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 provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

(2) **Newborns**. Providers must complete the NODOS/NB1 form (found on the OHCA website at https://oklahoma.gov/ohca/providers/forms.html) for a newborn child delivered by a SoonerCare member. A claim may then be filed for charges for the newborn under the case number and the newborn's name and assigned person code. Charges billed on the mother's person code for services rendered to the child will be denied.