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

SUBCHAPTER 3. GENERAL PROVISIONS

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare coverage guidelines for the categorically needy:

(1) Inpatient hospital services.

(A) Adult coverage for inpatient hospital stays as described at Oklahoma Administrative Code (OAC) 317:30-5-41.

(B) Coverage for members under twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or freestanding dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with the Oklahoma Health Care Authority (OHCA).

(6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified hospital-based facilities that are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.

(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.

(9) Maternity clinic services.

(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the Agency's Medical Authorization Unit.

(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.

(12) Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).

(13) Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or

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not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA child-health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.12.

(A) EPSDT screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.

(C) Immunizations.

(D) Outpatient care.

(E) Dental services as outlined in OAC 317:30-3-65.8.

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(G) Hearing services as outlined in OAC 317:30-3-65.9.

(H) Prescribed drugs.

(I) Outpatient psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.

(J) Inpatient psychiatric services as outlined in OAC 317:30-5-94 through 317:30-5-97.

(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.

(L) Inpatient hospital services.

(M) Medical supplies, equipment, appliances, orthotics and prosthetics.

(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members twenty-one (21) years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least thirty (30) days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a long-term care facility, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. ~~Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).~~

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(16) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider section for limitations to covered services for:

(A) Podiatrists' services;

(B) Optometrists' services;

(C) Psychologists' services;

(D) Certified registered nurse anesthetists;

(E) Certified nurse midwives;

(F) Advanced practice registered nurses; and

(G) Anesthesiologist assistants.

(17) Freestanding ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:

(A) Unlimited medically necessary monthly prescriptions for:

(i) Members under the age of twenty-one (21) years; and

(ii) Residents of long-term care facilities or ICF/IID.

(B) Seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) home and community-based services (HCBS) waivers. These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of medical supplies, equipment, and appliances.

(20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.

(21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).

(22) For non-expansion adults, prosthetic devices are limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure. There is no coverage for orthotic devices for adults.

(23) Orthotics and prosthetics, including prosthetic hearing implants and ocular prosthetics, are covered for expansion adult members, above the limitations within (22) of this Section, when prescribed by the treating provider (physician, physician assistant, or an advanced practice registered nurse) and medical necessity is documented in accordance with OAC 317:30-5-211.13.

(24) Standard medical supplies.

(25) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is

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limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(26) Blood and blood fractions for members when administered on an outpatient basis.
(27) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
(28) Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.
(29) Inpatient psychiatric facility admissions for members are limited to an approved length of stay with provision for requests for extensions.
(30) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
(31) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for twelve (12) months after the pregnancy ends regardless of the reason, beginning on the last date of pregnancy.
(32) Long-term care facility services for members under twenty-one (21) years of age.
(33) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a registered nurse (RN).
(34) Medicare Part A, Part B, and Part C deductibles, coinsurance, and copays.
(35) HCBS for the intellectually disabled.
(36) Home health services can be provided without a PA for the first thirty-six (36) visits. A PA will be required beyond the 36th ~~36th~~ visit. The visits are limited to any combination of RN and nurse aide visits.
(37) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) All transplantation services, except kidney and cornea, must be prior authorized;

(B) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;

(C) All organ transplants must be performed at a Medicare approved transplantation center;

(D) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and

(E) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(38) HCBS for intellectually disabled members who were determined to be inappropriately placed in a long-term care facility (Alternative Disposition Plan - ADP).
(39) Case management services for the chronically and/or seriously mentally ill.

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(40) Emergency medical services, including emergency labor and delivery for undocumented or ineligible aliens.
(41) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.
(42) Early intervention services for children ages zero (0) to three (3).
(43) Residential behavior management in therapeutic foster care setting.
(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
(45) HCBS for aged or physically disabled members.
(46) Outpatient ambulatory services for members infected with tuberculosis.
(47) Smoking and tobacco use cessation counseling for children and adults.
(48) Services delivered to American Indians/Alaskan Natives (AI/AN) in Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us). Payment is made on an encounter basis.
(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.
(50) Residential substance use disorder (SUD) services.
(51) Medication-assisted treatment (MAT) services.
(52) Diabetes self-management education and support (DSMES).

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 (2) 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 twenty-four (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 twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(7) Non-therapeutic hysterectomies.
(8) Induced abortions, ~~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~~ except as authorized pursuant to OAC 317:30-5-6 or 317:30-5-50.

(9) Medical services considered experimental or investigational. For more information regarding coverage of clinical trials, see Oklahoma Administrative Code (OAC) 317:30-3-57.1.

(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 and/or licensed physical therapist assistant. Per OAC 317:30-5-291.

(13) Services of an independent licensed occupational therapist and/or occupational therapist assistant. Per OAC 317:30-5-296.

(14) Services of a psychologist.

(15) Services of an independent licensed speech-language pathologist, speech-language pathology assistant (SLPA), and/or speech-language clinical fellow. Per OAC 317:30-5-675.

~~(16) Payment for more than four (4) outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.~~

~~(17) Payment for more than two (2) long-term care facility visits per month.~~

~~(18)~~(16) More than one (1) inpatient visit per day per physician.

~~(19)~~(17) Payment for removal of benign skin lesions.

~~(20)~~(18) 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.

~~(21)~~(19) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

~~(22)~~(20) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in the Oklahoma Health Care Authority (OHCA) rules.

~~(23)~~(21) Mileage.

~~(24)~~(22) A routine hospital visit on the date of discharge unless the member expired.

~~(25)~~(23) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

~~(26)~~(24) Fertility treatment.

~~(27)~~(25) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

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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) 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, but is not limited to, 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 (1) 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.

(G) Outpatient physician services including primary care, specialty care, and direct physician services in a nursing facility.

~~(G) Physician services on an outpatient basis include:~~

~~(i) A maximum of four (4) visits per member per month, including primary care or specialty care, with the exception of SoonerCare Choice members.~~

~~(ii) Additional visits are allowed per month for treatment related to emergency medical conditions and family planning services.~~

~~(H) Direct physician services in a nursing facility.~~

~~(i) A maximum of two (2) nursing facility visits per month are allowed; and if the visit (s) is for psychiatric services, it must be provided by a psychiatrist or a physician with appropriate behavioral health training.~~

~~(ii) To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the explanation of Medicare benefits (EOMB) showing denial and mark "carrier denied coverage."~~

~~(I)~~(H) Diagnostic x-ray and laboratory services.

~~(J)~~(I) Mammography screening and additional follow-up mammograms as per current guidelines.

~~(K)~~(J) Obstetrical care.

~~(L)~~(K) Pacemakers and prostheses inserted during the course of a surgical procedure.

~~(M)~~(L) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, Oklahoma Department of Human Services (OKDHS) form 08MA016E, Authorization for Examination and Billing, must accompany the claim.

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~~(N)~~(M) 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)~~(N) Family planning includes sterilization procedures for legally competent members twenty-one (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)~~(O) Genetic counseling.

~~(Q)~~(P) Laboratory testing.

~~(R)~~(Q) Payment for ultrasounds for pregnant women as specified in Oklahoma Administrative Code (OAC) 317:30-5-22.

~~(S)~~(R) 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)~~(S) 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; and

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

~~(U)~~(T) Payment for services rendered by medical residents in an outpatient academic setting when the following conditions are met:

(i) The resident has obtained a medical license or a special license for training from the appropriate regulatory state medical board; and

(ii) Has the appropriate contract on file with the OHCA to render services within the scope of their licensure.

~~(V)~~(U) The payment to a physician for medically directing the services of a certified registered nurse anesthetist (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.

~~(W)~~(V) Screening and follow up pap smears as per current guidelines.

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~~(X)~~(W) Medically necessary organ and tissue transplantation services for children and adults are covered services based upon the conditions listed in (i)-(v) of this subparagraph:

(i) All transplantation services, except kidney and cornea, must be prior authorized;

(ii) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;

(iii) All organ transplants must be performed at a Medicare-approved transplantation center;

(iv) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and

(v) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

~~(Y)~~(X) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure. Donor expenses that occur after the ninety (90) day global reimbursement period must be submitted to the OHCA for review.

~~(Z)~~(Y) Total parenteral nutritional (TPN) therapy for identified diagnoses and when prior authorized.

~~(AA)~~(Z) Ventilator equipment.

~~(BB)~~(AA) Home dialysis equipment and supplies.

~~(CC)~~(BB) 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.

~~(DD)~~(CC) Smoking and tobacco use cessation counseling for treatment of members 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 (8) sessions are covered per year per individual.

(iii) Smoking and tobacco use cessation counseling is a covered service when performed by physicians, physician assistants (PA), advanced registered nurse practitioners (ARNP), certified nurse midwives (CNM), dentists, Oklahoma State

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Health Department (OSDH) and Federally Qualified Health Center (FQHC) nursing staff, and maternal/child health licensed clinical social worker trained as a certified tobacco treatment specialist (CTTS). It is reimbursed in addition to any other appropriate global payments for obstetrical care, primary care provider (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 that addresses the 5A's and office note signature along with the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3) minutes is considered part of a routine visit and not separately billable.

~~(EE)~~(DD) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

~~(FF)~~(EE) Genetic testing and other molecular pathology services are covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition, is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified) or has been diagnosed with a condition where identification of specific genetic changes will impact treatment or management; and

(ii) Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular marker; and

(iv) A medical geneticist, physician, or licensed genetic counselor provides documentation that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include, but is not limited to, 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 (2) 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) Routine eye examinations for the sole purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of lenses, frames or visual aids.

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(E) Pre-operative care within twenty-four (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 twenty-one (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. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.
~~(J) Payment for more than four (4) outpatient visits per member (home or office) per month, except visits in connection with family planning, services related to emergency medical conditions, or primary care services provided to SoonerCare Choice members.~~
~~(K) Payment for more than two (2) nursing facility visits per month.~~
~~(L)~~(J) More than one (1) inpatient visit per day per physician.
~~(M)~~(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.
~~(N)~~(L) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
~~(O)~~(M) 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)~~(N) 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)~~ as authorized pursuant to OAC 317:30-5-6 or 317:30-5-50.
~~(Q)~~(O) Speech and hearing services.
~~(R)~~(P) Mileage.
~~(S)~~(Q) A routine hospital visit on the date of discharge unless the member expired.
~~(T)~~(R) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
~~(U)~~(S) Inpatient chemical dependency treatment.
~~(V)~~(T) Fertility treatment.
~~(W)~~(U) Payment for removal of benign skin lesions.

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(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of twenty-one (21) within the scope of the 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. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. 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 twenty-one (21) years of age must be prior authorized by an agency designated by the OHCA. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) All inpatient 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) For out of state placements, refer to OAC 317:30-3-89 through 317:30-3-92.

(2) **General Acute inpatient service limitations.** All general Acute inpatient hospital services for members under the age of twenty-one (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 twenty-one (21) years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment (EPSDT) program.** Payment is made to eligible providers for EPDST of members under age twenty-one (21). These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.12 for specific guidelines.

(6) **Reporting suspected abuse and/or neglect.** Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, Section 1-2-101 of Title 10A of the Oklahoma Statutes and 43A O.S. § 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (OKDHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local OKDHS county office, municipal

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or county law enforcement authorities, or, if the report occurs after normal business hours, the OKDHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

(7) **General exclusions.** The following are excluded from coverage for members under the age of twenty-one (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 (2) 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 twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by CPT and 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 twenty-one (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. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

(I) More than one (1) 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)~~as authorized pursuant 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.

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(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 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 ninety (90) days of the date of Medicare payment and within one (1) 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 ninety (90) days of the Medicare payment and within one (1) 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 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 Healthcare Common Procedure Coding System (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 (4) office visits (or home) per month per member, for adults [over age twenty-one (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 (4) per month limitation.~~

~~(3)~~(1) Payment is allowed for the insertion and/or implantation of contraceptive devices in addition to the office visit.

~~(4)~~(2) 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; and

(D) IV fluids.

~~(5)~~(3) Medically necessary office lab and X-rays are covered.

~~(6)~~(4) Hearing exams by physician for members between the ages of twenty one (21) and sixty five (65) are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.

~~(7)~~(5) Hearing aid evaluations are covered for members under twenty one (21) years of age.

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~~(8)~~(6) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.

~~(9)~~(7) Payment is made for an office visit in addition to allergy testing.

~~(10)~~(8) Separate payment is made for antigen.

~~(11)~~(9) Eye exams are covered for members between ages twenty one (21) and sixty five (65) for medical diagnosis only.

~~(12)~~(10) 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.

(11)~~(13)~~ Separate payment is made for the following specimen collections:

(A) Catheterization for collection of specimen; and

(B) Routine venipuncture.

(12)~~(14)~~ 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.

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

(14)~~(16)~~ Payment may be made for medication-assisted treatment (MAT) medications prescribed and/or administered by a physician.

(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 twenty-one (21) and sixty-five (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.

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(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 (1) 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 out-patient 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 (2)~~ nursing facility visits ~~per month. The~~when 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.

317:30-5-10. Ophthalmology services

(a) **Covered services for adults.**

(1) Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury ~~up to the patient's maximum number of allowed office visits per month~~.

(2) There is no provision for routine eye exams, examinations for the purpose of prescribing glasses or visual aids, determination of refractive state or treatment of refractive errors, or purchase of lenses, frames, or visual aids. Payment is made for treatment of medical or surgical conditions which affect the eyes. Providers must notify members in writing of services not covered by SoonerCare prior to providing those services. Determination of refractive state or other non-covered service may be billed to the patient if properly notified.

(3) The global surgery fee allowance includes preoperative evaluation and management services rendered the day before or the day of surgery, the surgical procedure, and routine postoperative period. Co-management for cataract surgery is filed using appropriate CPT codes, modifiers and guidelines. If an optometrist has agreed to provide postoperative care, the optometrist's information must be in the referring provider's section of the claim.

(b) **Covered services for children.**

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(1) Eye examinations are covered when medically necessary. Determination of the refractive state is covered when medically necessary.

(2) Payment is made for certain corrective lenses and optical supplies when medically necessary. Refer to OAC 317:30-5-432.1. for specific guidelines.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

(d) **Procedure codes.**

(1) The appropriate procedure codes used for billing eye care services are found in the Current Procedural Terminology (CPT) and HCPCS Coding Manuals.

(2) Vision screening is a component of all eye exams performed by ophthalmologists or optometrists and is not billed separately.

317:30-5-11. Psychiatric services

(a) Payment is made for procedure codes listed in the psychiatry section of the most recent edition of the American Medical Association Current Procedural Terminology (CPT) codebook. The codes in this service range are accepted services within the SoonerCare program for children and adults with the following exceptions:

(1) Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.

(2) Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient.

(3) Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers.

(4) Unlisted psychiatric service or procedure.

(b) All services must be medically necessary and appropriate and include at least one (1) diagnosis from the most recent version of the Diagnosis and Statistical Manual of Mental Disorders (DSM).

(c) Services in the psychiatry section of the CPT manual must be provided by a board eligible or board certified psychiatrist or a physician, physician assistant, or nurse practitioner with additional training that demonstrates the knowledge to conduct the service performed.

(d) Psychiatric services performed via telemedicine are subject to the requirements found in Oklahoma Administrative Code (OAC) 317:30-3-27.

(e) ~~With the exception of the two (2) allowable direct physician services in a nursing facility (refer to OAC 317:30-5-2), reimbursement~~Reimbursement for psychiatric services to members residing in a nursing facility is not allowed. Provision of these services is the responsibility of the nursing facility and reimbursement is included within the all-inclusive per diem payment that nursing facilities receive for the member's care.

317:30-5-15. Chemotherapy injections

(a) **Outpatient.**

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(1) Outpatient chemotherapy is compensable only when a malignancy is indicated or for the diagnosis of Acquired Immune Deficiency Syndrome (AIDS). Outpatient chemotherapy treatments are unlimited. ~~Outpatient visits in connection with chemotherapy are limited to four per month.~~

(2) Payment for administration of chemotherapy medication is made under the appropriate National Drug Code (NDC) and HCPCS code as stated in OAC 317:30-5-14(b). Payment is made separately for office visit and administration under the appropriate CPT code.

(3) When injections exceed listed amount of medication, show units times appropriate quantity, i.e., injection code for 100 mgm but administering 300, used 100 mgm times 3 units.

(4) Glucose - fed through IV in connection with chemotherapy administered in the office is covered under the appropriate NDC and HCPCS code.

(b) **Inpatient.**

(1) Inpatient hospital supervision of chemotherapy administration is non-compensable. The hospital visit in connection with chemotherapy could be allowed within our guidelines if otherwise compensable, but must be identified by description.

(2) Hypothermia - Local hypothermia is compensable when used in connection with radiation therapy for the treatment of primary or metastatic cutaneous or subcutaneous superficial malignancies. It is not compensable when used alone or in connection with chemotherapy.

(3) The following are not compensable:

(A) Chemotherapy for Multiple Sclerosis;

(B) Efudex;

(C) Oral Chemotherapy;

(D) Photochemotherapy;

(E) Scalp Hypothermia during Chemotherapy; and

(F) Strep Staph Chemotherapy.

PART 3. HOSPITALS

317:30-5-42.4. Clinic/treatment room services; urgent care

(a) An outpatient hospital clinic is a non-emergency service providing diagnostic, preventive, curative and rehabilitative services on a scheduled basis.

(b) Urgent care payment is made for services provided in non-emergency clinics operated by a hospital. This payment does not include the professional charges of the treating physician, nurse practitioner, physician assistant or charges for diagnostic testing. A facility charge is also allowed when drug and/or blood are administered outpatient.

(c) Urgent Care services will not require a referral for SoonerCare Choice members however other claims will deny without a referral.

~~(d) Adults are limited to four clinic visits per month.~~

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PART 23. PODIATRISTS

317:30-5-261. Coverage by category

Payment is made to podiatrists as set forth in this Section:

(1) **Adults.** Payment is made for medically necessary surgical procedures, x-rays, and outpatient visits. Procedures which are generally considered as preventative foot care, i.e. cutting or removal of corns, warts, callouses, or nails, are not covered unless the diagnoses on the claim, i.e. diabetes, multiple sclerosis, cerebral vascular accident, peripheral vascular disease establishes the medical necessity for the service. The patient must be under the active care of a doctor of medicine or osteopathy who documents the condition. All services must be medically appropriate and related to systemic disease for which foot care is viewed as preventative in nature. Nursing home visits must be ordered by the attending physician. The nursing home record must contain appropriate documentation that the visit was not performed for screening purposes. A specific foot ailment, symptom or complaint must be documented. In instances where the examination is performed in response to specific symptoms or complaints which suggests the need for care, the visit is compensable regardless of the resulting diagnosis. ~~All outpatient visits are subject to existing visit limitations.~~

(2) **Children.** Coverage of podiatric services for children is the same as for adults. Refer to OAC 317:30-3-57 (13) for additional coverage under the Early and Periodic Screening, Diagnosis and Treatment Program.

(3) **Individuals eligible for Part B of Medicare.** Payment for podiatric services is made utilizing the Medicaid allowable for comparable services.

PART 45. OPTOMETRISTS

317:30-5-431. Coverage by category

Payment is made to optometrists as set forth in this Section.

(1) **Adults.** Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury ~~up to the patient's maximum number of allowed office visits per month~~.

(A) There is no provision for routine eye exams, examinations for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors, or purchase of lenses, frames, or visual aids. Payment is made for treatment of medical or surgical conditions which affect the eyes. Prior to providing noncovered services, providers must notify members in
writing of those services not covered by SoonerCare. Determination of refractive state or other non-covered services may be billed to the patient if properly notified.

(B) The global surgery fee allowance includes preoperative evaluation and management services rendered the day before or the day of surgery, the surgical procedure, and routine postoperative period. Co-management for cataract surgery is

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filed using appropriate CPT codes, modifiers and guidelines. If an optometrist has agreed to provide postoperative care, the surgeon's information must be in the referring provider's section of the claim.

(C) Payment for laser surgery to optometrist is limited to those optometrists certified by the Board of Optometry as eligible to perform laser surgery.

(2) **Children.** Eye examinations are covered when medically necessary. Determination of the refractive state is covered when medically necessary.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

PART 35. RURAL HEALTH CLINICS

317:30-5-356. Coverage for adults

Payment is made to RHCs for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for one (1) encounter per member per day. ~~Payment is also limited to four (4) visits per member per month. This limit may be exceeded if the SoonerCare Choice member has elected the RHC as his/her/their Patient Centered Medical Home/Primary Care Provider. Preventive service exceptions include:~~

(A) **Obstetrical care.** An RHC should have a written contract with its physician, PA, APRN, or CNM that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for RHC and other ambulatory services.

(i) If the clinic compensates the physician, PA, APRN, or CNM to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.

(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, PAs, APRNs and CNMs (refer to OAC 317:30-5-22).

(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

~~(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one (1) of the four (4) RHC visits per month.~~

(2) **Other ambulatory services.** These services are not considered a part of an RHC visit; therefore, these may be billed to the SoonerCare program by the RHC or service provider on the appropriate claim form. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare

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program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

~~(A) Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors.~~

~~(B) There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)~~

317:30-5-361. Billing

(a) **Encounters.** Payment is made for one (1) encounter per member per day. Encounters with more than one (1) health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Medical review will be required for additional visits ~~for children. Payment is also limited to four (4) visits per member per month for adults. This limit may be exceeded if the SoonerCare Choice member has elected the RHC as his/her/their Patient Centered Medical Home/Primary Care Provider~~. RHCs must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

(1) **RHC.** The appropriate revenue code is required. No HCPCS or CPT code is required.

(2) **Mental health.** Mental health services must include a revenue code and a HCPCS code.

(3) **Obstetrical care.** The appropriate revenue code and HCPCS code are required. The date the member is first seen is required. The primary pregnancy diagnosis code is also required. Secondary diagnosis codes are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.

(4) **Family planning.** Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.

(5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the CPT Manual. Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist for members under the age of twenty-one (21).

(6) **Dental.** Dental services for children must be billed on the appropriate dental claim form.

(A) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.

(B) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.

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(7) **Visual analysis.** Visual analysis services for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Visual analysis services are billed using the appropriate revenue code and a HCPCS code. Payment is made directly to the RHC on an encounter basis for on-site optometric services by a licensed optometrist for members under the age of twenty-one (21).

(b) **Services billed separately from encounters.**

(1) Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges from the physical location where services were rendered/performed.

(A) **Laboratory.** The RHC must be CLIA certified for specialized laboratory services performed. Laboratory services must be itemized separately using the appropriate CPT or HCPCS code.

(B) **Radiology.** Radiology must be identified using the appropriate CPT or HCPC code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.

(C) **Immunizations.** The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.

(D) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required.

(E) **Eyeglasses.** Eyeglasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code. Payment is limited to two eyeglasses per year. Any eyeglasses beyond this limit must be prior authorized and determined to be medically necessary.

(2) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.3. FQHC encounters

(a) FQHC encounters that are billed to the Oklahoma Health Care Authority (OHCA) must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by an authorized health care professional listed in the approved FQHC State Plan pages within the scope of their licensure trigger a Prospective Payment System (PPS) encounter rate.

(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a FQHC within a twenty-four (24) hour

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period ending at midnight, as documented in the member's medical record. Services delivered via audio-only telecommunications do not constitute an encounter.

(c) An FQHC may bill for one (1) medically necessary encounter per twenty-four (24) hour period when the appropriate modifier is applied. Medical review will be required for additional visits for children. For information about multiple encounters, refer to Oklahoma Administrative Code (OAC) 317:30-5-664.4. ~~Payment is limited to four (4) visits per member per month for adults. This limit may be exceeded if the SoonerCare Choice member has elected the FQHC as his/her/their Patient Centered Medical Home/Primary Care Provider.~~

(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:

(1) Medical;

(2) Diagnostic;

(3) Dental, medical and behavioral health screenings;

(4) Optometry;

(5) Physical therapy;

(6) Occupational therapy;

(7) Podiatry;

(8) Behavioral health;

(9) Speech;

(10) Hearing;

(11) Medically necessary FQHC encounters with a registered nurse or licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3); and

(12) Any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the FQHCs scope of services when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to the services of a physician, PA, APRN, CNM, CP, CSW, MFT, and MHC are reimbursable within the encounter, as described in 42 C.F.R § 405.2413 and OAC 317:30-5-661.1.

(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

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