MEDICAL ADVISORY COMMITTEE MEETING
AGENDA
May 15, 2014
1:00 p.m. – 3:30pm
Charles Ed McFall Board Room
4345 N Lincoln Blvd
Oklahoma City, OK 73105

I. Welcome, Roll Call, and Dr. Crawford's Comments, Introduction of new delegates and alternates.

II. Approval of Minutes of the March 26, 2014 Medical Advisory Committee Meeting

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Legislative Review: Carter Kimble, OHCA Director of Governmental Relations

VI. Report on Budget: Carrie Evans, OHCA Chief Financial Officer

VII. Financial Report: Gloria Hudson, OHCA Director of General Accounting
   a. March 31, 2014 Financial Summary
   b. March 31, 2014 Financial Detail Report

VIII. SoonerCare Operations Update: Melody Anthony, OHCA Provider Services Director

IX. Action Items: Joseph Fairbanks, OHCA Policy Development Coordinator
   a. Discussion on Proposed Rule Changes
   b. Vote on Proposed Rule Changes

X. Informational Items (No Discussion): Joseph Fairbanks

   a. Department of Mental Health and Substance Abuse Services: Proposed Cuts to Behavioral Health Services

XI. New Business

XII. Adjourn

Next Meeting: Thursday, July 17, 2014, 4345 Lincoln, OKC

MEDICAL ADVISORY COMMITTEE MEETING
MINUTES
MARCH 26, 2014

Delegates present: Ms. Bellah, Ms. Bierig, Ms. Booten-Hiser, Ms. Brinkley, Dr. Crawford, Ms. Felty, Dr. Gastorf, Ms. Hastings, Mr. Jones, Dr. McNeill, Dr. Post, Dr. Rhoades, Dr. Rhynes, Dr. Simon, Ms. Slatton-Hodges, Mr. Tallent, Dr. Woodward, and Dr. Wright

Alternates present: Mr. Clay for Ms. Moran, Dr. Hamil for Dr. Bourdeau, Ms. Harrison for Mr. Snyder, Ms. Pryor for Ms. Fritz, Mr. Raybern for Ms. Galloway,

Delegates absent: Ms. Case, Dr. Cavallaro, Mr. Goforth, Dr. Grogg, Ms. Mays, Mr. Patterson, and Dr. Wells

I. Chairman, Dr. Crawford, called the meeting of the Medical Advisory Committee (MAC) to order at 1:35 PM noting that this would be the last meeting to be held at Shepherd Mall. He introduced an alternate for the National Association of Social Workers, Oklahoma Chapter, Frannie Pryor. Roll was called and a quorum was established. Dr. Crawford asked that members who have not submitted photographs for a pictorial directory remain after the meeting to be photographed.

II. Dr. Crawford requested that the minutes of the January 30, 2014 MAC meeting be corrected to reflect Dr. Post's proper title. Mr. Tallent moved that the minutes be approved as amended. Dr. Post seconded. There were no comments and the vote contained no dissent.

III. Public comments
   a. Rick Simon of NuMotion expressed concerns that the formula for pricing complex rehab technology products used in Proposed Rule Change (PRC) 13-12, Prior Authorization for manually-priced items, would reduce access. Two specific products that he said would be impacted were gait-trainers and standing frames as well as repairs on any Durable Medical Equipment (DME).
   b. Cynthia Willis from Northcare expressed support for PRC 13-48 Providers Under Supervision for Licensure.
   c. Kathy Wheat, Program Director of Speech Language Pathology at Oklahoma City Community College, addressing PRCs 13-43 Therapy provider qualifications and 13-52 School Based Services, told of a shortage in rural Oklahoma for speech-language pathologists and service providers to provide therapy services. She opposed the removal of Speech Language Therapy Assistants (SLTA) as eligible providers.
   d. Sara Baker, president of the Oklahoma Speech Language and Hearing Association also opposed PRCs 13-43 and 13-52 pointing out that Occupational Therapy and Physical Therapy employ assistants who are reimbursed.
   e. Jeff Wills, COO and owner of Option One expressed support for PRC 13-12.
   f. Michelle Longo, Executive Vice President for NuMotion, added to Mr. Simon's objection to 13-12 saying that it would be an administrative nightmare due to the amount of paperwork.
   g. Robert Lobato, Youth Care of Oklahoma owner, favored the PRC for therapists under supervision working through an agency rather than independently.

IV. There were no general comments or discussion from MAC members.

V. Nico Gomez, OHCA Chief Executive Officer, handed out a listing of possible budget cuts and reported on the meetings held with OHCA provider partners/stakeholders about budget reductions. He said that with current income projections, “no one is untouched;” we have to "share the pain" as Doctor Doug Cox, the Senate's appropriations chair put it. Mr. Gomez said that OHCA was doing its best to keep the rate at which providers are reimbursed from being cut. A lively discussion touched on areas of therapy services,

federal guidelines and matching monies, adult services versus services to children (not targeted), optometry, and mental health services.

  a. Carter Kimble, OHCA Director of Government Affairs, reviewed the current status of bills before the Oklahoma Legislature and identified one, HB 2384, that would have a major impact on the agency and was still active. HB 2384, co-authored by Representative Dr. Doug Cox and Senator Brian Crain, calls for a broad range of cuts to OHCA's appropriations. Mr. Kimble noted that two bills which would have assigned managed care models to the agency had died, but may return in the next session. Dr. Woodward gave state providers the credit for helping to kill those bills.

VI. Gloria Hudson, Director of General Accounting presented the Financial Summary and Detail Report for OHCA for the period ending December 31, 2013. There were no questions or comments.

VII. Becky Pasternik-Ikard, Deputy Director of Medicaid, reported on SoonerCare membership and expenditures as of December 2013 without MAC comment or questions.

  a. Mary Ann Dimery, Behavioral Health Specialist, presented the Behavioral Health Screening initiative that is being incorporated into Patient-Centered Medical Homes over the next two years.
  b. Dane Libart from the Oklahoma Department of Mental Health and Substance Abuse Services followed up with a more detailed presentation about SBIRT: Screening, Brief Intervention and Referral to Treatment.
    i. Concerns were raised about the amount of time needed to use SBIRT and other screening tools, but the studies of the tool's use showed a high level of effectiveness in improving long-term outcomes for 25% of the total population having “risky alcohol use.” Mr. Libart responded to a question about referrals stating that inpatient facilities were scare, but there were a greater number of outpatient providers to help.

VIII. Joseph Fairbanks, Policy Development Coordinator, asked for and was granted permission to present all of the Proposed Rule Changes (PRCs) and then have the committee vote for the group with the exception of the PRCs extracted for individual voting.

  a. There was no discussion surrounding PRCs 13-26 Genetic Testing, 13-27 Infectious Disease Billing, 13-30 Audit Appeals, 13-35 Electronic Fund Transfer Enrollment, 13-53 Laboratory Payment Rates, and 13-51 Fluoride Varnish.
  b. Stan Ruffner, DME Program Director, presented detailed information about PRC 13-12, Prior Authorization for Manually-Priced Items, carried over from the 1/31/14 MAC meeting and reviewed by the DME Advisory Council on March 13. Mr. Fairbanks noted that the pricing methodology was changed to a lower rate: MSRP less 30% or invoice plus 30%. He also noted that a tiered system suggested at the DME Advisory Council meeting could not be implemented at this time but could be considered as a future PRC.
  c. PRCs 13-13 Long-Acting reversible Contraceptive Devices and 13-11 340B Drug Discount Program were presented without discussion.
  d. PRC 13-52 School Based Services prompted discussion about the removal of Speech-Language Therapist Assistants (SLTAs) in the language. Mr. Fairbanks contrasted the educational requirements for SLTAs, a Bachelors degree, versus an Associates degree for Speech-Language Pathologist Assistants (SLPA).
    i. Mr. Fairbanks said that SLTAs are not licensed as SLPAs are and must be to be recognized by the Centers for Medicaid and Medicare Services (CMS). Nor do federal guidelines currently identify SLPAs as a provider type, but OHCA is working on changing that. He addressed a concern of Ms. Bierig about a backlog of Prior Authorization requests in rural areas

where there were few licensed providers by saying that the PA requirement will be postponed until the beginning of 2015.

e. PRCs 13-24 Advantage Address Confidentiality Program and 13-25 aDvantaage Billing Procedures did not draw discussion.
f. Ms. Felty expressed concern about the requirements of PRC 13-34 Policy Change for Tax Equity Fiscal Responsibility Act (TEFRA) Program to do a psychological evaluation at age 16 when Social Security Insurance does not recognize the evaluation and requires an evaluation at age 18. A member of the public familiar with TEFRA commented that the PRC lines up with Federal Blue Book guidelines for TEFRA. Ms. Bellah echoed Ms. Felty's concern about unneeded expenditures. Mr. Tallent asked that PRC 13-34 be extracted from the group vote.
g. After Mr. Fairbanks presented PRC 13-43, Ms. Bierig pointed out that Occupational Therapy Assistants (OTAs) and Physical Therapy Assistants (PTAs) were not nationally certified yet were eligible for reimbursement by federal rules. State licensure requirements, she pointed out, are more stringent than national certification requirements for SLPAs. Mr. Fairbanks responded that OHCA is working on getting CMS approval for adding SLPAs. Mr. Jones asked for and received clarification that SLPAs, OTAs, and PTAs could work independently if they are not still in training.
h. Mr. Fairbanks presented PRC 13-50 Therapeutic Foster Care (TFC) and clarified a question about TFC services and those authorized for DD+ group homes.
i. Traylor Rains presented the rest of the Behavioral Health PRCs.
j. PRC 13-45 Inpatient Psychiatric Rules, 13-46 Outpatient Behavioral Health Services, 13-47 Bio-Psychosocial Evaluations, 13-48 Providers Under Supervision for Licensure, and 13-49 Transitional Case Management were presented without question or comment.
k. Mr. Tallent moved to accept the PRCs as a group with PRC 13-34 extracted. Dr. Rhynes asked to have 13:52 extracted; Ms. Bierig asked to have 13:43 extracted; Dr. Hamil requested to have 13-30, 13-46, and 13-47 extracted. Ms. Felty seconded the motion.
    i. Dr. McNeill pointed out that the language of PRC 13-26 concerning genetic testing contained language about pap smears that would need to come back to a future meeting of MAC to meet current guidelines.
l. PRCs 13-26 Genetic Testing, 13-27 Infectious Disease Billing, 13-35 Electronic Fund Transfer Enrollment, 13-53 Laboratory Payment Rates, 13-51 Fluoride Varnish, 13-12 Prior authorization for manually-priced items, 13-13 Long Acting Reversible Contraceptive Devices, 13-11 340B Drug Discount Program, 13-24 ADvantage Address Confidentiality Program, 13-25 ADvantage Billing Procedures, 13-48 Providers Under Supervision for Licensure, 13-49 Transitional Care Management, and 13-50 Therapeutic Foster Care were approved without any dissenting votes.

IX. Proposed Rule Changes that were extracted

a. Mr. Tallent explained that he requested to extract PRC 13-34 because a psychological evaluation that had been allowable was now being mandated. Ms. Felty noted that this PRC went against the move to cut costs. Mr. Tallent moved that the language be changed to say, "the evaluation can be administered after the age of six for justification." Ms. Felty seconded the motion. Dr. Hamil noted that the PRC also adjusts the threshold from 75 to 70 and asked if those in that range would have to be re-tested or pushed out of the program. Ms. Felty assured him that this change would not push anyone out. Dr. Crawford called for the vote and PRC 13-43 was unanimously passed with the language change.
b. Dr. Rhynes talked about his concern about the definition of "state certified vision impairment teacher" and confusing wording in Section (D) Vision in PRC 13-52

School Based Services. Dr. Crawford suggested separating the paragraph into two parts and Mr. Fairbanks said he would clarify the language before going to the board. Dr. Rhynes moved for approval, Dr. McNeill seconded and the motion passed without a dissenting vote.

c. Dr. Hamil objected to adding language to the policy as suggested in PRC 13-30 Audit Appeals that would put the burden of proof on providers. Jerry Streck, OHCA Legal Services, pointed out that although the language is new, the process is required by another statute. Mr. Tallent moved to approve 13-30, Ms. Bellah seconded and the vote was all in favor with one "nay."

d. In PRC 13-47, Dr. Hamil took exception to allowing Masters level behavioral health providers to be paid for pre-surgery assessments when the standards for bariatric surgeons call for a psychologist to do the assessment. Dr. Post asked if the change would allow for double billing and Dr. Lopez said it would not. Mr. Tallent moved to approve 13-47, Ms. Bellah seconded and the vote was all in favor with two against.

X. Informational Items

a. Mr. Fairbanks informed the committee about waiver amendments and a state plan amendment that were being developed and would be presented at a later MAC meeting.

XI. New Business

a. Ms. Bierig asked if PRC 13-43 Therapy Provider Qualifications had been voted upon. After some discussion about whether or not it had been voted upon, a hand vote of those who believed or did not believe that 13-43 had been voted on went in favor of those who believed the vote was taken.

XII. Adjournment

a. Dr. Wright moved to adjourn, Dr. Gastorf seconded and the meeting was adjourned without dissent at 4:35 PM.

Potential Budget Cuts

This document is a comprehensive list of potential budget reductions. This is not a recommendation. It is intended to help guide discussions and develop recommendations should budget reductions be required. (May 5, 2014 -draft)

Potential Budget Reductions	Estimated Total Savings	Estimated State Savings (37.27%)
Administrative Reductions		
Agency operations reduction	6,141,576	3,071,288
(this does not include contracted services)		
Medicaid Optional Adult Benefits		
Dental Program Reductions	8,075,106	3,009,592
Elimination of Perinatal Dental Benefits plus other dental changes		
Targeted Program Changes		
Durable Medical Equipment (DME) Changes	2,797,964	1,042,801
Prior Authorize Oxygen after 90 days	2,000,000	745,400
Convert Blood Glucose supplies to competitive bid national rate	797,964	297,401
(33% reduction $16 to $10 / unit)		
Exclude Members with Third Party Liability from Medical Homes	3,887,634	1,448,921
Federally Qualified Health Centers / Rural Health Centers Visit Limit	218,331	81,372
limits to 4 / month for adults and 1 / day for everyone		
Hospital Readmissions	18,783,264	7,000,523
Reduce hospital readmissions occurring w/in 30 days		
($62.6 m spend on readmissions; assuming a 30% savings)		
Implement Prior Authorization for all Sleep Studies	1,238,194	311,475
(sfy13 totals $4.1 m; assuming a 30% reduction w/ PA. would also impact subsequent CPAP)		
Implement Prior Authorization for all Back & Spinal Surgeries	4,566,343	1,551,876
Physician	849,378	241,563
Hospital	3,716,965	1,310,313
(sfy13 totals $15.2 m; assuming a 30% reduction w/ PA)		
Increase Cost Sharing Amounts to the Federal Limit	8,294,160	3,091,234
(raising pharmacy copays to $4 even on zero copay generics)		
Limit number of pairs of glasses we pay for children to 2 pair / year	347,055	129,347
(PA all glasses over 2)		
Nursing Homes	3,106,334	1,157,731
Eliminate payment for leave days		
Pharmacy	7,900,000	2,944,330
Require PA for all controlled substances (includes net of administrative cost)		
Physician crossover claims	8,229,146	3,067,003
Reduce payment of co-insurance from 100% to 83.75%		
Total of Admin and Program Changes	**73,585,107**	**27,907,492**

DRAFT

Provider Payment Reductions				
Changes in Appropriations	**Flat**	**-1.25%**	**-2.50%**	**-5.00%**
Across the board cuts / additional state share needed	55,768,480	67,689,746	79,611,012	103,453,544
(results in total dollar impact)	149,633,700	181,619,925	213,606,150	277,578,599
with Nursing Facilities (1% cut = 7.8 m state)	6.48%	7.86%	9.25%	12.02%
without Nursing Facilities (1% cut = 6.5 m state)	7.81%	9.48%	11.15%	14.49%

Assumes a loss of 13.7 m in tobacco tax revenue
Assumes 20 m additional in carryover
Assumes a July implementation with 1 month claim lag; an 11 month impact
Each 1% cut to Nursing Facilities results in another 2.1 m loss to them from QoC

FINANCIAL REPORT

For the Nine Months Ended March 31, 2014
Submitted to the CEO & Board

- Revenues for OHCA through March, accounting for receivables, were **$2,896,800,470** or **.3% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,861,892,884 or 1.9% under** budget.
- The state dollar budget variance through March is **$46,919,661 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		22.5
Administration		5.6
Revenues:		
Unanticipated Revenue		15.7
Drug Rebate		8.2
Taxes and Fees		(3.2)
Overpayments/Settlements		(1.9)
Total FY 14 Variance	**$**	**46.9**

ATTACHMENTS

Summary of Revenue and Expenditures: OHCA 1
Medicaid Program Expenditures by Source of Funds 2
Other State Agencies Medicaid Payments 3
Fund 205: Supplemental Hospital Offset Payment Program Fund 4
Fund 230: Quality of Care Fund Summary 5
Fund 245: Health Employee and Economy Act Revolving Fund 6
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund 7

Oklahoma Health Care Authority

Summary of Revenues & Expenditures: OHCA

Fiscal Year 2014, For the Nine Months Ended March 31, 2014

REVENUES	FY14 Budget YTD	FY14 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 703,277,269	$ 703,277,269	$ -	0.0%
Federal Funds	1,535,574,433	1,497,956,272	(37,618,161)	(2.4)%
Tobacco Tax Collections	41,785,146	38,525,739	(3,259,407)	(7.8)%
Quality of Care Collections	60,374,163	60,374,163	-	0.0%
Prior Year Carryover	41,811,007	41,811,007	-	0.0%
Unanticipated Revenue	-	15,683,810	15,683,810	100.0%
Federal Deferral - Interest	174,064	174,064	-	0.0%
Drug Rebates	155,296,128	177,999,647	22,703,519	14.6%
Medical Refunds	36,419,448	31,326,035	(5,093,413)	(14.0)%
SHOPP	317,120,356	317,120,356	-	0.0%
Other Revenues	12,402,719	12,552,107	149,388	1.2%
TOTAL REVENUES	**$ 2,904,234,734**	**$ 2,896,800,470**	**$ (7,434,264)**	**(0.3)%**

EXPENDITURES	FY14 Budget YTD	FY14 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 43,499,454**	**$ 37,091,438**	**$ 6,408,016**	**14.7%**
ADMINISTRATION - CONTRACTS	**$ 88,768,887**	**$ 81,589,467**	**$ 7,179,420**	**8.1%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	27,654,167	27,110,451	543,717	2.0%
Acute Fee for Service Payments:				
Hospital Services	707,461,163	690,928,148	16,533,015	2.3%
Behavioral Health	16,489,228	15,775,383	713,845	4.3%
Physicians	382,168,283	373,500,390	8,667,892	2.3%
Dentists	112,231,067	106,385,081	5,845,985	5.2%
Other Practitioners	34,653,992	31,889,292	2,764,700	8.0%
Home Health Care	16,595,150	15,282,497	1,312,653	7.9%
Lab & Radiology	50,422,506	43,181,263	7,241,243	14.4%
Medical Supplies	38,198,619	34,976,922	3,221,697	8.4%
Ambulatory/Clinics	87,551,241	82,757,141	4,794,099	5.5%
Prescription Drugs	317,541,450	332,489,998	(14,948,548)	(4.7)%
OHCA TFC	1,294,122	1,476,607	(182,485)	0.0%
Other Payments:				
Nursing Facilities	433,824,156	428,194,904	5,629,253	1.3%
ICF-MR Private	44,834,142	44,295,602	538,540	1.2%
Medicare Buy-In	101,831,497	102,213,436	(381,939)	(0.4)%
Transportation	47,029,640	48,684,256	(1,654,617)	(3.5)%
MFP-OHCA	1,217,362	751,588	465,774	0.0%
EHR-Incentive Payments	13,964,314	13,964,314	-	0.0%
Part D Phase-In Contribution	57,659,719	58,087,436	(427,717)	(0.7)%
SHOPP payments	291,267,268	291,267,268	-	0.0%
Total OHCA Medical Programs	**2,783,889,087**	**2,743,211,980**	**40,677,107**	**1.5%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,916,246,810**	**$ 2,861,892,884**	**$ 54,353,925**	**1.9%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (12,012,076)**	**$ 34,907,586**	**$ 46,919,661**	

Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2014, For the Nine Months Ended March 31, 2014

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 27,367,371	$ 27,097,649	$ -	$ 256,920	$ -	$ 12,802	$ -
Inpatient Acute Care	577,910,682	449,033,116	365,015	7,128,391	33,827,799	1,433,907	86,122,453
Outpatient Acute Care	213,669,139	203,069,826	31,203	7,400,828	-	3,167,282	-
Behavioral Health - Inpatient	17,909,593	9,405,239	-	409,029	-		8,095,325
Behavioral Health - Psychiatrist	6,370,144	6,370,144	-	-	-	-	-
Behavioral Health - Outpatient	19,092,456	-	-	-	-	-	19,092,456
Behavioral Health Facility- Rehab	207,291,977	-	-	-	-	64,072	207,291,977
Behavioral Health - Case Management	7,463,552	-	-	-	-	-	7,463,552
Behavioral Health - PRTF	69,746,505	-	-	-	-	-	69,746,505
Residential Behavioral Management	15,534,613	-	-	-	-	-	15,534,613
Targeted Case Management	48,868,019	-	-	-	-	-	48,868,019
Therapeutic Foster Care	1,476,607	1,476,607	-	-	-	-	-
Physicians	416,364,112	323,540,671	43,576	9,553,510	45,267,799	4,648,344	33,310,212
Dentists	106,437,499	101,753,058	-	52,417	4,609,616	22,407	-
Mid Level Practitioners	2,690,066	2,636,383	-	50,898	-	2,785	-
Other Practitioners	29,447,287	28,217,276	334,773	197,163	690,537	7,538	-
Home Health Care	15,282,616	15,261,100	-	119	-	21,397	-
Lab & Radiology	45,570,375	42,705,867	-	2,389,111	-	475,396	-
Medical Supplies	35,424,575	32,908,843	2,033,652	447,654	-	34,427	-
Clinic Services	86,000,525	75,388,199	-	915,659	-	180,729	9,515,938
Ambulatory Surgery Centers	7,512,984	7,174,632	-	324,771	-	13,582	-
Personal Care Services	9,934,591	-	-	-	-	-	9,934,591
Nursing Facilities	428,194,904	243,176,706	157,823,173	-	27,186,702	8,323	-
Transportation	48,501,040	44,344,808	1,978,104	-	2,136,176	41,953	-
GME/IME/DME	90,708,628	-	-	-	-	-	90,708,628
ICF/MR Private	44,295,602	35,541,833	8,183,689	-	570,080	-	-
ICF/MR Public	29,383,077	-	-	-	-	-	29,383,077
CMS Payments	160,300,872	159,756,504	544,368	-	-	-	
Prescription Drugs	345,451,095	299,760,745	-	12,961,098	31,491,364	1,237,888	-
Miscellaneous Medical Payments	183,295	175,710	-	79	-	7,506	-
Home and Community Based Waiver	127,994,316	-	-	-	-	-	127,994,316
Homeward Bound Waiver	67,074,403	-	-	-	-	-	67,074,403
Money Follows the Person	7,171,265	751,588	-	-	-	-	6,419,677
In-Home Support Waiver	17,767,416	-	-	-	-	-	17,767,416
ADvantage Waiver	137,277,219	-	-	-	-	-	137,277,219
Family Planning/Family Planning Waiver	8,621,459	-	-	-	-	-	8,621,459
Premium Assistance*	34,420,938	-	-	34,420,938		-	-
EHR Incentive Payments	13,964,314	13,964,314	-	-	-	-	-
SHOPP Payments**	291,267,268	291,267,268	-	-	-	-	-
Total Medicaid Expenditures	**$ 3,819,942,400**	**$2,123,510,819**	**$ 171,337,552**	**$ 76,508,584**	**$ 145,780,075**	**$ 11,380,338**	**$1,000,221,836**

* Includes $4,164,683.66 paid out of Fund 245 and **$182,116,227.02 paid out of Fund 205

Oklahoma Health Care Authority

Summary of Revenues & Expenditures: Other State Agencies
Fiscal Year 2014, For the Nine Months Ended March 31, 2014

REVENUE	FY14 Actual YTD
Revenues from Other State Agencies	$ 412,593,239
Federal Funds	643,771,267
TOTAL REVENUES	**$ 1,056,364,506**

EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	$ 127,994,316
Money Follows the Person	6,419,677
Homeward Bound Waiver	67,074,403
In-Home Support Waivers	17,767,416
ADvantage Waiver	137,277,219
ICF/MR Public	29,383,077
Personal Care	9,934,591
Residential Behavioral Management	11,358,985
Targeted Case Management	36,692,225
Total Department of Human Services	**443,901,910**
State Employees Physician Payment	
Physician Payments	33,310,212
Total State Employees Physician Payment	**33,310,212**
Education Payments	
Graduate Medical Education	44,367,799
Graduate Medical Education - PMTC	3,070,674
Indirect Medical Education	31,088,706
Direct Medical Education	12,181,449
Total Education Payments	**90,708,628**
Office of Juvenile Affairs	
Targeted Case Management	2,164,105
Residential Behavioral Management	4,175,628
Total Office of Juvenile Affairs	**6,339,733**
Department of Mental Health	
Case Management	7,463,552
Inpatient Psych FS	8,095,325
Outpatient	19,092,456
PRTF	69,746,505
Rehab	207,291,977
Total Department of Mental Health	**311,689,814**

State Department of Health	
Children's First	1,633,720
Sooner Start	1,659,561

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

Fiscal Year 2014, For the Nine Months Ended March 31, 2014

REVENUES		FY 14 Revenue
SHOPP Assessment Fee	$	130,505,579
Federal Draws		186,450,970
Interest		142,925
Penalties		20,881
State Appropriations		(22,700,000)
TOTAL REVENUES	$	294,420,356

EXPENDITURES	Quarter	Quarter	*Thru Fund 340* Quarter		FY 14 Expenditures
Program Costs:	7/1/13 - 9/30/13	10/1/13 - 12/31/13	1/1/13 - 3/31/13		
Hospital - Inpatient Care	76,710,371	86,962,208	87,919,865	$	251,592,444
Hospital -Outpatient Care	2,748,407	2,899,948	14,433,147	$	20,081,502
Psychiatric Facilities-Inpatient	5,785,055	6,483,431	6,540,191	$	18,808,677
Rehabilitation Facilities-Inpatient	248,410	278,398	257,838	$	784,646
Total OHCA Program Costs	85,492,242	96,623,985	109,151,041	$	291,267,268
Total Expenditures				$	291,267,268
CASH BALANCE				$	3,153,088

Oklahoma Health Care Authority

SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2014, For the Nine Months Ended March 31, 2014

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 58,486,331**	**$ 58,486,331**
Interest Earned	**31,044**	**31,044**
TOTAL REVENUES	**$ 58,517,375**	**$ 58,517,375**

EXPENDITURES	FY 14 Total $ YTD	FY 14 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 155,077,449	$ 55,827,882	
Eyeglasses and Dentures	210,763	75,875	
Personal Allowance Increase	2,534,960	912,586	
Coverage for DME and supplies	2,033,651	732,115	
Coverage of QMB's	774,567	278,844	
Part D Phase-In	544,368	544,368	
ICF/MR Rate Adjustment	4,123,856	1,484,588	
Acute/MR Adjustments	4,059,833	1,461,540	
NET - Soonerride	1,978,104	712,117	
Total Program Costs	**$ 171,337,551**	**$ 62,029,914**	**$ 62,029,914**
Administration			
OHCA Administration Costs	$ 352,917	$ 176,458	
PHBV - QOC Exp	-	-	
OSDH-NF Inspectors	800,000	800,000	
Mike Fine, CPA	9,500	4,750	
Total Administration Costs	**$ 1,162,417**	**$ 981,208**	**$ 981,208**
Total Quality of Care Fee Costs	**$ 172,499,968**	**$ 63,011,122**	
TOTAL STATE SHARE OF COSTS			**$ 63,011,122**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

Oklahoma Health Care Authority

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2014, For the Nine Months Ended March 31, 2014

REVENUES	FY 13 Carryover	FY 14 Revenue	Total Revenue
Prior Year Balance	$ 10,427,850	$ -	$ 3,651,001
State Appropriations	-	-	(3,000,000)
Tobacco Tax Collections	-	31,686,489	31,686,489
Interest Income	-	165,115	165,115
Federal Draws	375,153	22,761,765	22,761,765
All Kids Act	(6,791,717)	191,651.65	191,652
TOTAL REVENUES	**$ 4,011,287**	**$ 54,805,020**	**$ 55,264,369**

EXPENDITURES	FY 13 Expenditures	FY 14 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 33,712,480	$ 33,712,480
College Students		256,324	256,324
All Kids Act		452,203	452,203
Individual Plan			
SoonerCare Choice		$ 246,789	$ 88,844
Inpatient Hospital		7,114,331	2,561,159
Outpatient Hospital		7,288,085	2,623,711
BH - Inpatient Services-DRG		394,211	141,916
BH -Psychiatrist		-	-
Physicians		9,478,465	3,412,247
Dentists		35,939	12,938
Mid Level Practitioner		50,138	18,050
Other Practitioners		191,059	68,781
Home Health		119	43
Lab and Radiology		2,364,573	851,246
Medical Supplies		443,516	159,666
Clinic Services		898,258	323,373
Ambulatory Surgery Center		323,913	116,609
Prescription Drugs		12,808,273	4,610,978
Miscellaneous Medical		79	79
Premiums Collected		-	(58,741)
Total Individual Plan		**$ 41,637,747**	**$ 14,930,899**
College Students-Service Costs		**$ 369,737**	**$ 133,105**
All Kids Act- Service Costs		**$ 80,162**	**$ 28,858**
Total OHCA Program Costs		**$ 76,508,654**	**$ 49,513,870**
Administrative Costs			
Salaries	$ 7,360	$ 797,575	$ 804,935
Operating Costs	85,634	595,336	680,971
Health Dept-Postponing	-	-	-
Contract - HP	267,291	815,717	1,083,008
Total Administrative Costs	**$ 360,286**	**$ 2,208,629**	**$ 2,568,914**
Total Expenditures			**$ 52,082,784**
NET CASH BALANCE	**$ 3,651,001**		**$ 3,181,585**

Oklahoma Health Care Authority

SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
Fiscal Year 2014, For the Nine Months Ended March 31, 2014

REVENUES	FY 14 Revenue	State Share
Tobacco Tax Collections	$ 632,315	$ 632,315
TOTAL REVENUES	**$ 632,315**	**$ 632,315**

EXPENDITURES	FY 14 Total $ YTD	FY 14 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 12,802	$ 3,226	
Inpatient Hospital	1,433,907	361,345	
Outpatient Hospital	3,167,282	798,155	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	8,323	2,097	
Physicians	4,648,344	1,171,383	
Dentists	22,407	5,647	
Mid-level Practitioner	2,785	702	
Other Practitioners	7,538	1,900	
Home Health	21,397	5,392	
Lab & Radiology	475,396	119,800	
Medical Supplies	34,427	8,676	
Clinic Services	180,729	45,544	
Ambulatory Surgery Center	13,582	3,423	
Prescription Drugs	1,237,888	311,948	
Transportation	41,953	10,572	
Miscellaneous Medical	7,506	1,892	
Total OHCA Program Costs	$ 11,316,266	$ 2,851,699	
OSA DMHSAS Rehab	$ 64,072	$ 16,146	
Total Medicaid Program Costs	$ 11,380,338	$ 2,867,845	
TOTAL STATE SHARE OF COSTS			**$ 2,867,845**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

March 2014 Data for May 2014 Board Meeting

SoonerCare 1

SOONERCARE ENROLLMENT/EXPENDITURES

SoonerCare Program report Delivery System		Monthly Enrollment Average SFY2013	Enrollment March 2014	Total Expenditures March 2014	Average Dollars Per Member Per Month March 2014
SoonerCare Choice Patient-Centered Medical Home		513,315	**583,231**	**$148,337,439**	
Lower Cost	(Children/Parents; Other)		536,742	$105,648,558	$197
Higher Cost	(Aged, Blind or Disabled; TEFRA; BCC)		46,489	$42,688,880	$918
SoonerCare Traditional		217,231	**198,798**	**$187,427,054**	
Lower Cost	(Children/Parents; Other)		90,259	$51,402,901	$570
Higher Cost	(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)		108,033	$136,024,154	$1,259
SoonerPlan*		48,346	**48,821**	**$556,994**	$11
Insure Oklahoma		30,202	**19,570**	**$6,460,395**	
Employer-Sponsored Insurance		16,644	14,750	$3,860,308	$262
*Individual Plan**		13,559	4,820	$2,600,087	$539
TOTAL		**809,094**	**850,420**	**$342,781,883**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data. Custody expenditures are excluded. Non-member specific expenditures of $35,972,610 are excluded.

*In January 2014, SoonerPlan's qualifying income guidelines decreased from 185% to 133% of FPL and Insure Oklahoma IP's qualifying income guidelines decreased from 200% to 100% of FPL.

Net Enrollee Count Change from Previous Month Total**	12,706

**The increase in Net Enrollees was mostly due to the requirement to maintain coverage through March 2014.

New Enrollees	18,437

Members that have not been enrolled in the past 6 months.

Dual Enrollees & Long-Term Care Members (subset of data above)

Medicare and SoonerCare		Monthly Average SFY2013	Enrolled March 2014
Dual Enrollees		**108,514**	**109,645**
	Child	201	189
	Adult	108,313	109,456

		Monthly Average SFY2013	Enrolled March 2014	FACILITY PER MEMBER PER MONTH
Long-Term Care Members		**15,674**	**15,321**	**$3,419**
	Child	64	67	
	Adult	15,610	15,254	

Child is defined as an individual under the age of 21.

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2013	Enrolled March 2014
Total Providers		**36,948**	**38,998**
	In-State	28,587	29,765
	Out-of-State	8,362	9,233

Provider Network includes providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and specialties.

Program	% of Capacity Used
SoonerCare Choice	45%
SoonerCare Choice I/T/U	18%
Insure Oklahoma IP	1%

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2013	*Enrolled March 2014**	Monthly Average SFY2013	Enrolled March 2014
Physician	*7,859*	*8,534*	*12,432*	13,932
Pharmacy	*901*	*945*	*1,208*	1,277
Mental Health Provider**	*5,811*	*5,093*	*5,880*	5,133
Dentist**	*1,205*	*1,013*	*1,380*	1,133
Hospital**	*194*	*184*	*923*	756
Optometrist	*578*	*575*	*612*	605
Extended Care Facility	*362*	*356*	362	356

Above counts are for specific provider types and are not all-inclusive.

Total Primary Care Providers***	*4,997*	*5,481*	6,541	7,054
Patient-Centered Medical Home	*1,935*	*2,104*	1,985	2,192

Including Physicians, Physician Assistants and Advance Nurse Practitioners.

*Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

**Decrease in current month's count is due to contract renewal period which is typical during all renewal periods. Hospitals renewal started in March 2013, renewals for Mental Health Providers started in June 2013 and Dentist renewals started in October 2013.

ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

The Electronic Health Records Incentive Program is a federal program that offers major financial support to assist certain providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology.

Unduplicated Provider Totals	
Total Providers Paid	**Total Payment Amount**
2,015	$131,757,717

Providers Paid - Since Inception								
	Participation Year 1				Participation Year 2		Participation Year 3	
	Adopt/Implement/Upgrade		Meaningful Use		Meaningful Use		Meaningful Use	
	Total Providers Paid	Total Payment Amount	Total Providers Paid	Total Payment Amount	Total Providers Paid	Total Payment Amount	Total Providers Paid	Total Payment Amount
Eligible Hospital	88	$54,571,190	6	$1,836,850	45	$27,671,970	11	$1,512,788
Eligible Professional	1,886	$40,035,002	33	$701,250	621	$5,275,667	18	$153,000
Totals	1,974	$94,606,192	39	$2,538,100	666	$32,947,637	29	$1,665,788
				Participation Year Totals - Since Inception			2,708	$131,757,717

Providers Paid - March 2014								
	Participation Year 1				Participation Year 2		Participation Year 3	
	Adopt/Implement/Upgrade		Meaningful Use		Meaningful Use		Meaningful Use	
	Total Providers Paid	Total Payment Amount	Total Providers Paid	Total Payment Amount	Total Providers Paid	Total Payment Amount	Total Providers Paid	Total Payment Amount
Eligible Hospital	0	$0.00	1	$428,669	2	$680,000	1	$45,000
Eligible Professional	3	$63,750	6	$127,500	6	$51,000	11	$93,500
Totals	3	$63,750	7	$556,169	8	$731,000	12	$138,500
				Participation Year Totals - March 2014			30	$1,489,419

Adopt/Implement/Upgrade: Acquiring or purchasing/Installing or utilizing/Expanding the functionality of certified EHR technology.

Meaningful Use: Using certified EHR technology to: Improve quality, safety, efficiency, and reduce health disparities; Engage patients and family; Improve care coordination, and population and public health; Maintain privacy and security of patient health information.

Proposed Rule Changes Summaries

These rules were posted for comment on May 1, 2014 and will remain open for comment through May 31, 2014.

Face to face tribal consultations regarding the proposed changes were held Tuesday, May 6, 2014 in the Board room of the OHCA.

14-02 **FQHC & RHC Encounter Limitation —** Rules are revised to limit encounters within Federal Qualified Health Centers (FQHC) and Rural Health Clinic Services (RHC) to one encounter per member per day as well as limit encounters to a total of four visits per member per month for adults. These revisions do not apply to members in a medical home.
Budget Impact: $218,331 **Total Savings** and $81,372 **State Share**

14-03 **Elimination of Hospital & Therapeutic Leave —** Rules are revoked to eliminate payment to nursing facilities to reserve beds for members who are absent from the facility. Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital.
Budget Impact: $3,106,334 **Total Savings** and $1,157,751 **State Share**

14-04 **Hospital Readmissions —** Rules are amended to reduce/deny payment for preventable readmissions that occur within 30 days from discharge. The current policy allows for reviews of readmissions occurring within 15 days.
Budget Impact: $18,783,264 **Total Savings** and $7,000,523 **State Share**

14-05 **Cost Sharing —** Agency's cost-sharing rules are revised to permit an increase of copays to the federal maximum.
Budget Impact: $8,294,160 **Total Savings** and $3,091,234 **State Share**

14-06 **Dental —** Rules are revised to eliminate the perinatal dental benefit, coverage for pulp cap indirect and therapeutic pulpotomies, and coverage for intraoral-occlusal film and bitewings-four film radiographic images.
Budget Impact: $8,075,106 **Total Savings** and $3,009,592 **State Share**

14-07 **Oxygen — —** Rules are revised to require a prior authorization after the initial three months. In addition, rules are revised to clarify arterial blood gas analysis (ABG) and pulse oximetry testing and Certificate of Medical Necessity requirements.
Budget Impact: $2,000,000 **Total Savings** and $745,400 **State Share**

14-08 **Limiting Reimbursement for Eyeglasses —** Rules are amended to limit the number of payments for glasses to two per year. Any additional glasses beyond this limit must be prior authorized and determined to be medically necessary.
Budget Impact: $347,055 **Total Savings** and $129,347 **State Share**

14-09 **SoonerCare Choice Enrollment Ineligibility —** SoonerCare Choice rules regarding enrollment ineligibility are amended to include making individuals with other forms of creditable health insurance coverage ineligible for SoonerCare Choice. Additionally, members who are currently enrolled in SoonerCare Choice who have or gain other forms of creditable insurance will be disenrolled from SoonerCare Choice.
Budget Impact: $3,887,634 **Total Savings** and $1,448,921 **State Share**

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 35. RURAL HEALTH CLINICS

317:30-5-355.1. **Definition of services**

The RHC benefit package, as described in Title 42 of the Code of Federal Regulations (CFR), part 440.20, consists of two components: RHC Services and Other Ambulatory Services.

(1) **RHC services.** RHC services are covered when furnished to a member at the clinic or other location, including the member's place of residence. These services are described in this Section.

(A) **Core services.** As set out in Federal Regulations at 42 CFR 440.20(b), RHC "core" services include, but are not limited to:

(i) Physician's services;

(ii) Services and supplies incident to a physician's services;

(iii) Services of advanced practice nurses (APNs), physician assistants (PAs), nurse midwives (NMs) or specialized advanced practice nurse practitioners;

(iv) Services and supplies incident to the services of APNs and PAs (including services furnished by nurse midwives);

(v) Visiting nurse services to the homebound;

(vi) Clinical psychologist (CP) and clinical social worker (CSW) services;

(vii) Services and supplies incident to the services of CPs and CSWs.

(B) **Physicians' services.** In addition to the professional services of a physician, and services provided by an APN, PA and NMW which would be covered as RHC services under Medicare, certain primary preventive services are covered under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of a RHC practitioner who is a clinic employee:

(i) prenatal and postpartum care;

(ii) screening examination under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for members under 21;

(iii) family planning services;

(iv) medically necessary screening mammography and follow-up mammograms when medically necessary.

(C) **Services and supplies "incident to".** Services and supplies incident to the service of a physician, physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker are covered if the service or supply is:

(i) a type commonly furnished in physicians' offices;
(ii) a type commonly rendered either without charge or included in the rural health clinic's bill;
(iii) furnished as an incidental, although integral, part of a physician's professional services;
(iv) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(D) **Visiting nurse services.** Visiting nurse services are covered if:
(i) the RHC is located in an area in which the Centers for Medicare and Medicaid Services (CMS) has determined there is a shortage of home health agencies;
(ii) the services are rendered to members who are homebound;
(iii) the member is furnished nursing care on a part time or intermittent basis by a registered nurse, licensed practical nurse or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and
(iv) the services are furnished under a written plan of treatment.

(E) **RHC encounter.** RHC "core" services (including preventive services, i.e., prenatal, EPSDT or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and a RHC health professional (i.e., physicians, physician assistants, advanced practice nurses, nurse midwives, clinical psychologists and clinical social workers). Encounters with more than one 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. Payment is made for one encounter per member per day. Payment is also limited to four visits per member per month for adults.

(F) **Off-site services.** RHC services provided off-site of the clinic are covered as long as the RHC has a compensation arrangement with the RHC practitioner that SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The rural health clinic must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the rural health clinic services provided off-site are to be billed to SoonerCare. It is

expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) **Other ambulatory services.** A Rural Health Clinic must provide other items and services which are not "RHC services" as described in (a)(1) of this Section, and are separately billable to the SoonerCare program. Coverage of services are based upon the scope of coverage under the SoonerCare program.

(A) Other ambulatory services include, but are not limited to:

(i) dental services for members under age 21;

(ii) optometric services;

(iii) clinical lab tests performed in the RHC lab, including the lab tests required for RHC certification;

(iv) technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);

(v) durable medical equipment;

(vi) emergency ambulance transportation;

(vii) prescribed drugs;

(viii) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

(ix) specialized laboratory services furnished away from the clinic;

(x) inpatient services;

(xi) outpatient hospital services.

(B) Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist or optometric services by a licensed optometrist for members under age 21. Encounters are billed as one of the following:

(i) **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.

(ii) **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.

(iii) **Visual analysis.** Visual analysis (initial or yearly) 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. Glasses must be billed separately. <u>Payment is limited to two glasses per year. Any glasses beyond this limit must be</u>

<u>prior authorized and determined to be medically necessary.</u>

(C) Services listed in (a)(2)(A), (v)-(viii), of this Section, furnished on-site, require separate provider agreements with the OHCA. Service item (a)(2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

(D) 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.

317:30-5-356. Coverage for adults

Payment is made to rural health clinics for adult services as set forth in this Section.

(1) **RHC services.** ~~Payment is limited to four visits per member per month.~~<u>Payment is made for one encounter per member per day. Payment is also limited to four visits per member per month.</u> Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-65.2 for exceptions to ~~this~~<u>the four visit</u> limit for children under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Additional preventive service exceptions include:

(A) **Obstetrical care.** A Rural Health Clinic should have a written contract with its physician, nurse midwife, advanced practice nurse, or physician assistant 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 rural health and non-rural health clinic (other ambulatory) services.

(i) If the clinic compensates the physician, nurse midwife or advanced practice nurse 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, certified nurse midwives, physician assistants, and advanced practice nurses (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 of the four RHC visits per month.

(2) **Other ambulatory services.** Services defined as "other ambulatory" services are not considered a part of a RHC visit and are therefore billable to the SoonerCare program by the RHC or provider of service on the appropriate claim forms. Other ambulatory services are subject to the same scope of coverage as other SoonerCare services billed to the program, i.e., limited adult services and some services for under 21 subject to same prior authorization process. 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 program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. 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.)

317:30-5-357. Coverage for children

Coverage for rural health clinic services and other ambulatory services for children include the same services as for adults in addition to the following:

(1) The receipt of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) examination by a Medicaid eligible individual under age 21 renders that individual child eligible for all necessary follow-up care, whether or not the medically necessary services are covered under the Medicaid program. An EPSDT exam performed by a RHC must be billed on the appropriate claim form with the appropriate Preventative Medicine procedure code from the Current Procedural Terminology Manual (CPT). If an EPSDT screening is billed, a RHC encounter should not be billed on the same day. Refer to OAC 317:30-3-47 through 317:30-3-54 for coverages under EPSDT).

(2) Under EPSDT, coverage is allowed for visual screenings and eyeglasses to correct visual defects. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(3) An EPSDT screening is considered a comprehensive examination. A provider billing the Medicaid program for an EPSDT screen may not bill any other visits for that patient

on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. Additional services such as tests, immunizations, etc., required at the time of screening may be billed independently from the screening.

(4) The administration fee for immunizations should be billed if provided at the same time as a scheduled EPSDT examination.

(5) Payment may be made directly to the RHC for the professional services of physician assistants performing EPSDT screenings within the certified RHC. The claim form must include the signature of the supervising physician.

317:30-5-361. Billing

(a) **Encounters.** Payment is made for one ~~type of~~ encounter per member per day. Payment is also limited to four visits per member per month for adults. Rural health clinics 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 HCPC 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 Current Procedural Terminology Manual (CPT).

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

(7) **Visual analysis.** Optometric services for children are billed using the appropriate revenue code and a HCPCS code.

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

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

(2) **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.

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

(4) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required. The following are examples:

(A) DepoProvera 150 mg. (Medroxyprogesterone Acetate).
(B) Insertion and implantation of a subdermal contraceptive device.
(C) Removal, implantable contraceptive devices.
(D) Removal, with reinsertion, implantable contraceptive device.
(E) Insertion of intrauterine device (IUD).
(F) Removal of intrauterine device.
(G) ParaGard IUD.
(H) Progestasert IUD.

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

(6) **Telemedicine.** The originating site facility fee for telemedicine services is not a rural health clinic service. When a rural health clinic serves as the originating site, the originating site facility fee is paid separately from the clinic's all-inclusive rate.

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.3. Health Center encounters

(a) Health Center encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by the authorized health care professional on the approved FQHC state plan pages within the scope of their licensure trigger a 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 Health Center within a 24-hour period ending at midnight, as documented in the member's medical record.

(c) ~~For information about multiple encounters, refer to OAC 317:30-5-664.4.~~A Health Center may bill for one medically necessary encounter per 24 hour period. Payment is limited to four visits per member per month for adults.

(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) vision;
(5) physical therapy;
(6) occupational therapy;
(7) podiatry;
(8) behavioral health;
(9) speech;
(10) hearing;
(11) medically necessary Health Center encounters with a RN or LPN 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);
(12) any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the Health Center's 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 a physician's professional service are reimbursable within the encounter if the service or supply is:

(1) of a type commonly furnished in physicians' offices;
(2) of a type commonly rendered either without a charge or included in the health clinic's bill;
(3) furnished as an incidental, although integral, part of a physician's professional services;
(4) furnished under the direct, personal supervision of a physician; and
(5) in the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

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

317:30-5-664.4. Multiple encounters at Health Centers [REVOKED]

~~(a) A Health Center may bill for more than one medically necessary encounter per 24 hour period under certain conditions.~~

~~(b) It is intended that multiple medically necessary encounters will occur on an infrequent basis.~~

~~(c) A Center may not develop Center procedures that routinely involve multiple encounters for a single date of service, unless medical necessity warrant multiple encounters.~~

~~(d) Each service must have distinctly different diagnoses in order to meet the criteria for multiple encounters. For example, a medical visit and a dental visit on the same day are considered different services with distinctly different~~

~~diagnoses.~~
~~(e)Similar services, even when provided by two different health care practitioners, are not considered multiple encounters.~~

14-03 Elimination of Hospital & Therapeutic Leave

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 9. LONG TERM CARE FACILITIES

317:30-5-126. Therapeutic leave and Hospital leave [REVOKED]

~~Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made.~~

~~(1) Effective July 1, 1994, the nursing facility may receive payment for a maximum of seven (7) days of therapeutic leave per calendar year for each recipient to reserve the bed.~~

~~(2) Effective January 1, 1996, the nursing facility may receive payment for a maximum of five days of hospital leave per calendar year for each recipient to reserve the bed when the patient is admitted to a licensed hospital.~~

~~(3) The Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) may receive payment for a maximum of 60 days of therapeutic leave per calendar year for each recipient to reserve a bed. No more than 14 consecutive days of therapeutic leave may be claimed per absence. Recipients approved for ICF/IID on or after July 1 of the year will only be eligible for 30 days of therapeutic leave during the remainder of that year.~~

~~(4) Midnight is the time used to determine whether a patient is present or absent from the facility. The day of discharge for therapeutic leave is counted as the first day of leave, but the day of return from such leave is not counted. For hospital leave, the day of hospital admission is the first day of leave. The day the patient is discharged from the hospital is not counted as a leave day.~~

~~(5) Therapeutic and hospital leave balances are recorded on the Medicaid Management Information System (MMIS). When a patient moves to another facility, it is the responsibility of the transferring facility to forward the patient's leave records to the receiving facility.~~

14-04 Hospital Readmissions

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-56. Utilization review

All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment. In addition to the random sample of all admissions, retrospective review policy includes the following:

(1) Hospital stays less than three days in length will be reviewed for medical necessity and appropriateness of care. (Discharges involving healthy mother and healthy newborns may be excluded from this review requirement.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient stay will be denied.

(2) Cases which indicate transfer from one acute care hospital to another will be monitored to help ensure that payment is not made for inappropriate transfers.

(3) Readmissions occurring within ~~15~~30 days of prior acute care admission for a related condition will be reviewed to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the OHCA.

14.05 Cost Sharing

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-5. Assignment and Cost Sharing

(a) **Definitions.** The following words and terms, when used in subsection (c) of this Section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Fee-for-service contract"** means the provider agreement specified in OAC 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority and medical providers which provides for a fee with a specified service involved.

(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.

(3) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.

(b) **Assignment in fee-for-service.** The OHCA's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or co-payment required by the State Plan to be paid by the member and make no additional charges to the member or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Provider Services.

(3) When potential assignment violations are detected, the OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the OHCA is required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a fee for service contract and also executes a contract with a provider in the SoonerCare Choice program must adhere to the rules of this

subsection regarding assignment.

(1) If the service provided to the member is outside of the scope of the services outlined in the SoonerCare Contract, then the provider may bill or seek collection from the member.

(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) of this subsection, the Oklahoma Health Care Authority shall be the final authority for this decision.

(3) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.

(d) **Cost Sharing-Copayment.** Section 1902(a)(14) of the Social Security Act permits states to require certain members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the fee for service program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges and it does not preclude the provider from attempting to collect the co-payment.

(1) Co-payment is not required of the following members:

(A) Individuals under age 21. Each member's date of birth is available on the REVS system or through a commercial swipe card system.

(B) Members in nursing facilities and intermediate care facilities for the mentally retarded.

(C) Home and Community Based Service waiver members except for prescription drugs.

(D) Native Americans providing documentation of ethnicity in accordance with 317:35-5-25 who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.

(2) Co-payment is not required for the following services:

(A) Family planning services. Includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(C) Services furnished to pregnant women, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

(3) Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

(C) Ambulatory surgery visits including free-standing ambulatory surgery centers.

(D) Encounters with the following rendering providers:

(i) Physicians,

(ii) Advanced Practice Nurses,

(iii) Physician Assistants,

(iv) Optometrists,

(v) Home Health Agencies,

(vi) Certified Registered Nurse Anesthetists,

(vii) Anesthesiologist Assistants,

(viii) Durable Medical Equipment providers, and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

~~(i) Zero for preferred generics.~~

~~(ii) $0.65 for prescriptions having a SoonerCare allowable payment of $0.00-$10.00.~~

~~(iii) $1.20 for prescriptions having a SoonerCare allowable payment of $10.01-$25.00.~~

~~(iv) $2.40 for prescriptions having a SoonerCare allowable payment of $25.01-$50.00.~~

~~(v) $3.50 for prescriptions having a SoonerCare allowable payment of $50.01 or more.~~

(F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.

(4) Aggregate cost-sharing liabilities in a given calendar year may not exceed 5% of the member's gross annual income.

14-06 Dental

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 79. DENTISTS

317:30-5-696. Coverage by category

Payment is made for dental services as set forth in this Section.

(1) **Adults.**

(A) Dental coverage for adults is limited to:

(i) medically necessary extractions and~~;~~ approved boney adjustments. Surgical tooth extraction must have medical need documented if not apparent on images of tooth. In the SoonerCare program, it is usually performed for those teeth which are damaged to such extent that no tooth is visible above the gum line, the tooth fractures, the tooth is impacted, or tooth can't be grasped with forceps~~.~~;

(ii) Smoking and Tobacco Use Cessation Counseling; and

(iii) medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician.

(B) Payment is made for dental care for adults residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and who have been approved for ~~ICF/MR~~ICF/IID level of care, similar to the scope of services available to individuals under age 21.

(C) Pregnant women are covered under a limited dental benefit plan (Refer to (a)(4)of this Section).

(2) **Home and community based waiver services (HCBWS) for the intellectually disabled.** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under 21 years of age without prior authorization. All other dental services must be prior authorized. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** This procedure is performed for any member not seen by any dentist for more than 12 months.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if not seen by any dentist for more than six months.

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of a periodic oral examination or if the member is involved in active treatment unless trauma or acute infection is the presenting complaint. This procedure is only compensable to the same dentist or practice for two visits prior to an examination being completed.

(D) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include member history, prior radiographs, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Periapical radiograph must include at least 3 millimeters beyond the apex of the tooth being x-rayed. Panoramic films and full mouth radiographs (minimum of 12 periapical films and two posterior bitewings) are allowable once in a three year period and must be of diagnostic quality. Individually listed intraoral radiographs by the same dentist/—dental office are considered a complete series if the fee for individual radiographs equals or exceeds the fee for a complete series. Panoramic films are only compensable when chart documentation clearly indicates the test is being performed to rule out or evaluate non-caries related pathology discovered by prior examination. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through 18 years of age and is compensable only once per lifetime. Replacement of sealants is not a covered service under the SoonerCare program.

(F) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(G) **Composite restorations.**

(i) This procedure is compensable for primary incisors as follows:

(I) tooth numbers O and P to age 4 years;

(II) tooth numbers E and F to age 6 years;

(III) tooth numbers N and Q to 5 years; and

(IV) tooth numbers D and G to 6 years.

(ii) The procedure is also allowed for use in all vital and successfully treated non-vital permanent anterior

teeth.

(iii) Class I and II composite restorations are allowed in posterior teeth; however, the OHCA has certain restrictions for the use of this restorative material. (See OAC 317:30-5-699).

(H) **Amalgam.** Amalgam restorations are allowed in:

(i) posterior primary teeth when:

(I) 50 percent or more root structure is remaining;

(II) the teeth have no mobility; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) any permanent tooth, determined as medically necessary by the treating dentist.

(I) **Stainless steel crowns for primary teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:

(I) the child is five years of age or under;

(II) 70 percent or more of the root structure remains; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:

(I) primary teeth with pulpotomies or pulpectomies, if the above conditions exist;

(II) primary teeth where three surfaces of extensive decay exist; or

(III) primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.

(iv) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other restorative procedure on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(J) **Stainless steel crowns for permanent teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are the treatment of choice for:

(I) posterior permanent teeth that have completed endodontic therapy if three or more surfaces of tooth is destroyed;

(II) posterior permanent teeth that have three or more surfaces of extensive decay; or

(III) where cuspal occlusion is lost due to decay prior to age 16 years.

(ii) Preoperative periapical x-rays and/or written

documentation explaining the extent of decay must be available for review, if requested.

(iii) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other restorative procedure on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(K) ~~**Pulpotomies and pulpectomies.**~~**Pulpal therapy**. Pulpal therapy is allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.

~~(i) Therapeutic pulpotomies are allowable for molars and teeth numbers listed below. Pre-and post-operative periapical x-rays must be available for review, if requested.~~

~~(I) Primary molars having at least 70 percent or more of their root structure remaining or more than 12 months prior to normal exfoliation;~~

~~(II) Tooth numbers O and P before age 5 years;~~

~~(III) Tooth numbers E and F before 6 years;~~

~~(IV) Tooth numbers N and Q before 5 years;~~

~~(V) Tooth numbers D and G before 5 years.~~

~~(ii) Pulpectomies are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.~~

(L) **Endodontics.** Payment is made for the services provided in accordance with the following:

(i) This procedure is allowed when there are no other missing anterior teeth in the same arch requiring replacement.

(ii)The provider documents history of member's improved oral hygiene and flossing ability in records.

(iii) Prior authorization is required for members who have a treatment plan requiring more than two anterior and/or two posterior root canals.

(iv) Teeth with less than 60 percent of clinical crown should not be treatment-planned for root canal therapy.

(v) Pre and post-operative periapical x-rays must be available for review.

(vi) ~~Pulpotomy~~Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.

(vii) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for 24 month post completion.

(viii) Endodontically treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved

for any type of crown.

(M) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than 5mm below the crest of the alveolar ridge or where the successor tooth would not normally erupt in the next 12 months.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.

(III) If there are missing posterior teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim should be those of the missing teeth.

(V) Post-operative bitewing x-rays must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and the second primary molar (K or T) is missing in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age 4 years to prevent abnormal swallowing habits.

(IV) Pre and post-operative x-rays must be available.

(iii) **Interim partial dentures.** This service is for anterior permanent tooth replacement or if the member is missing three or more posterior teeth to age 16 years.

(N) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide

is compensable for four occurrences per year and is not separately reimbursable, if provided on the same date by the same provider as IV sedation, non-intravenous conscious sedation or general anesthesia. The medical need for this service must be documented in the member's record.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date by the same provider as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and /or the dentist, it must be medically necessary.

(O) **Pulp caps.** ~~Indirect and direct~~Direct pulp cap must be ADA accepted calcium hydroxide or Mineral Trioxide Aggregate materials, not a cavity liner or chemical used for dentinal hypersensitivity. ~~Indirect and direct~~Direct pulp cap ~~codes~~code ~~require~~requires specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect or direct pulp cap. Utilization of these codes is verified by post payment review.

(P) **Protective restorations.** This restoration includes removal of decay, if present, and are reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. Permanent restoration of the tooth is allowed after 60 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(Q) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.

(R) **Local anesthesia.** This procedure is included in the fee for all services.

(S) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, nurse midwives,

and Oklahoma State Health Department and FQHC nursing staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(T) **Periodontal scaling and root planing.** This procedure is designed for the removal of calculus or tissue that is contaminated and requires anesthesia and some soft tissue removal. This procedure requires that each tooth have 3 or more of the 6 point measurements 5 millimeters or greater, or have multiple areas of radiographic bone loss and subgingival calculus and must involve two or more teeth per quadrant for consideration. This procedure is not allowed on members under age 10. This procedure is not allowed in conjunction with any other periodontal surgery.

~~(4) **Pregnant Women.** Dental coverage for this special population is provided regardless of age.~~

~~(A) Proof of pregnancy is required (Refer to OAC 317:35-5-6).~~

~~(B) Coverage is limited to a time period beginning at the diagnosis of pregnancy and ending upon 60 days post partum.~~

~~(C) In addition to dental services for adults, other services available include:~~

~~(i) Comprehensive oral evaluation must be performed and recorded for each new member, or established member not seen for more than 24 months;~~

~~(ii) Periodic oral evaluation as defined in OAC 317:30-5-696(3)(B);~~

~~(iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an oral examination by the same provider for the same member, or if the member is under active treatment;~~

~~(iv) Radiographs as defined in OAC 317:30-5-696(3)(D);~~

~~(v) Dental prophylaxis as defined in OAC 317:30-5-696(3)(F);~~

~~(vi) Composite restorations:~~

~~(I) Any permanent tooth that has an opened lesion seen on radiograph or that is a documented food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.~~

~~(II) Class I One and two surface posterior composite resin restorations are allowed in posterior teeth that qualify;~~

~~(vii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and~~

~~(viii) Analgesia. Analgesia services are reimbursable~~

~~in accordance with OAC 317:30-5-696(3)(N).~~

~~(D) Services requiring prior authorization (Refer to OAC 317:30-5-698).~~

~~(E) Periodontal scaling and root. Procedure is designed for the removal of calculus or tissue that is contaminated and requires anesthesia and some soft tissue removal. This procedure requires that each tooth have 30 or more of the 6 point measurements 5 millimeters or greater, or have multiple areas of radiographic bone loss and subgingival calculus and must involve two or more teeth per quadrant for consideration. This procedure is not allowed on members under age 10. This procedure is not allowed in conjunction with any other periodontal surgery.~~

~~(5)~~(4) **Individuals eligible for Part B of Medicare.**

(A) Payment is made based on the member's coinsurance and deductibles.

(B) Services which have been denied by Medicare as non-compensable should be filed directly with the OHCA with a copy of the Medicare EOB indicating the reason for denial.

317:30-5-698. Services requiring prior authorization

(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis (See OAC 317:30-5-695(d)(2). Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. X-rays, six point periodontal charting and comprehensive treatment plans are required. Study models and narratives may be requested by OHCA or representatives of OHCA. If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense. Submitted documentation used to base a decision will not be returned.

(b) Requests for prior authorization are filed on the currently approved ADA form. OHCA notifies the provider on the determination of prior authorization using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.

(d) Listed below are examples of services requiring prior authorization for members under 21 and eligible ICF/IID residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays or images and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. X-rays must be

submitted with film mounts and each film or print must be of diagnostic quality. X-rays and/or images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All x-rays or images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed current ADA form requesting all treatments requiring prior authorization. The film, digital media or printout must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) **Endodontics.** Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document that the member has improved oral hygiene and flossing ability over a minimum of two months, in the member's records. ~~Pulpotomy~~Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics.

(A) Prior authorization is required for members who have a treatment plan requiring more than two anterior and/or two posterior root canals. All rampant, active caries must be removed prior to requesting anterior endodontics. Payment is made for services provided in accordance with the following:

(i) Permanent teeth only.

(ii) Accepted ADA materials must be used.

(iii) Pre and post-operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor.

(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.

(B) **Posterior endodontics.** The guidelines for this procedure are as follows:

(i) The provider documents that the member has improved oral hygiene and flossing ability over a minimum of two months, in this member's records.

(ii) Teeth that ~~would require~~ require pre-fabricated post and cores to retain a restoration due to lack of natural tooth structure should not be treatment planned for root canal therapy.

(iii) Pre and post-operative periapical x-rays must be

available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon proof of medical necessity.

(vi) Only ADA accepted materials are acceptable under the OHCA policy.

(vii) Posterior endodontic procedure may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(viii) Endodontics will not be considered if:

(I) an opposing tooth has super erupted;

(II) loss of tooth space is one third or greater;

(III) opposing second molars are involved unless prior authorized; or

(IV) the member has multiple teeth failing due to previous inadequate root canal therapy or follow-up~~.~~;

(V) all rampant, active caries must be removed prior to requesting posterior endodontics.

(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(2) **Crowns for permanent teeth.** Crowns are compensable for restoration of natural teeth for members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and who have been approved for (ICF/IID) level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure.

(i) all rampant, active caries must be removed prior to requesting any type of crown.

~~(i)~~(ii) The tooth must be decayed to such an extent to prevent proper cuspal or incisal function.

~~(ii)~~(iii) The clinical crown is fractured or destroyed by one-half or more.

~~(iii)~~(iv)Endodontically treated teeth must have three or more surfaces restored or lost due to carious activity to be considered for a crown.

(B) The conditions listed in (A)(i) through (A)~~(iii)~~(iv) of this paragraph should be clearly visible on the

submitted x-rays when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown. Non authorized restorative codes may be used if available.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, there is invasion of the biologic width, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed for molar or pre-molar teeth.

(E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.

(F) Provider is responsible for replacement or repair of all crowns if failure is caused by poor laboratory processes or procedure by provider for 48 months post insertion.

(3) **Cast frame partial dentures.** This appliance is the treatment of choice for replacement of missing anterior permanent teeth or two or more missing posterior teeth in the same arch for members 16 through 20 years of age. Provider must indicate which teeth will be replaced. Members must have excellent oral hygiene documented for at least 18 months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up for a period of two years post insertion.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of three or more missing teeth in the same arch for members 12 through 16 years of age. Provider must indicate tooth numbers to be replaced. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization. Model should not be made or sent unless requested.

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members 17 through 20 years of age will be considered for this treatment. Destruction of healthy teeth to replace a single missing tooth is not considered medically necessary. Members must have excellent oral hygiene documented for at least 18 months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up until member loses eligibility.

(7) **Periodontal scaling and root planing.** Procedure is designed for the removal of calculus or tissue that is contaminated and requires anesthesia and some soft tissue removal. This procedure requires that each tooth have 3 or more of the six point measurements 5 millimeters or greater,

or have multiple areas of radiographic bone loss and subgingival calculus and must involve two or more teeth per quadrant for consideration. This procedure is not allowed on members under the age 10. This procedure is not allowed in conjunction with any other periodontal surgery.

317:30-5-699. Restorations

~~(a) **Use of posterior composite resins.** Payment is not made for certain restorative services when posterior composite resins are used in restorations involving:~~

~~(1) replacement of any occlusal cusp or~~

~~(2) sub-gingival margins~~

~~(b)~~(a) **Utilization parameters.** The Oklahoma Health Care Authority utilization parameters allow only one permanent restorative service to be provided per tooth per 24 months. Additional restorations may be authorized upon approval of OHCA in cases of trauma. Teeth receiving a restoration are eligible within three months for consideration of single crown if endodontically treated. Providers must document type of isolation used in treatment progress notes. The provider is responsible for follow-up or any required replacement of a failed restoration, if the member is currently SoonerCare eligible. Fees paid for the original restorative services may be recouped if any additional treatments are required on the same tooth by a different provider within 12 months due to defective restoration or recurrent decay. If it is determined by the Dental Director that a member has received poorly rendered or insufficient treatment from a provider, the Dental Director may prior authorize corrective procedures by a second provider.

~~(c)~~(b)**Coverage for dental restorations.** Restoration of incipient lesions is not considered medically necessary treatment. Any diagnosis not supported by radiographs requires documentation of the medical need on which the diagnosis was made. Services for dental restorations are covered as follows:

(1) If the mesial occlusal pit and the distal occlusal pit on an upper molar tooth are restored at the same appointment, this is a one surface restoration.

(2) If any two separate surfaces on a posterior tooth are restored at the same appointment, it is a two surface restoration.

(3) If any three separate surfaces on a posterior tooth are restored at the same appointment, it is a three surface restoration.

(4) If the mesial, distal, facial and/or lingual of an upper anterior tooth is restored at the same appointment, this is a four surface restoration.

(5) If any two separate surfaces on an anterior tooth are restored at the same appointment, it is a two surface restoration.

(6) If any three separate surfaces on an anterior tooth are restored at the same appointment, it is a three surface restoration.

(7) An incisal angle restoration is defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. If any of these surfaces are restored at the same appointment, even if separate, it is considered as a single incisal angle restoration.

(8) When four or more separate surfaces on a posterior tooth are restored at the same appointment it is a four surface restoration.

(9) Wide embrasure cavity preparations do not become extra surfaces unless at least one half of cusp or surface is involved in the restoration. An MODFL restoration would have to include the mesial-occlusal-distal surfaces as well as either the buccal groove pit or buccal surface or at least one half the surface of one of the buccal cusps. The same logic applies for the lingual surface.

14.07 Oxygen

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.11. Oxygen and oxygen equipment

(a) **Medical necessity.** Oxygen and oxygen supplies are covered when medically necessary. Medical necessity is determined from results of arterial blood gas analysis (ABG) or pulse oximetry (SaO2) tests ~~(pO2)~~. ABG data are not required for children, but may be used if otherwise available. The test results to document Medical Necessity must be within 30 days of the date of the ~~physician's prescription.~~qualified medical practitioner's Certificate of Medical Necessity. Prior authorization is required after the initial three months of billing whether qualifying tests were done at rest, during sleep, or during exercise. Appropriate documentation of ABG or SaO2 data from the member's chart should be attached to the prior authorization request(PAR).~~A copy of a report from an inpatient or outpatient hospital or emergency room setting will meet the requirement.~~

(1) ~~For initial certification for oxygen, the ABG study or oximetry analysis used to determine medical necessity may not be performed by the DMEPOS or a related corporation. In addition, neither the study nor the analysis may be performed by a physician with a significant ownership interest in the DMEPOS performing such tests. These prohibitions include relationships through blood or marriage. A referring physician may perform the test in his/her office as part of routine member care.~~ The ABG or oximetry test used to determine medical necessity must be performed by a medical professional qualified to conduct such testing. The test may not be performed or paid for by a DMEPOS supplier, or a related corporation. A referring qualified medical practitioner may perform the test in his/her office as part of routine member care.

(2) ~~Initial certification is for no more than three months. Except in the case of sleep-induced hypoxemia, ABG or oximetry is required within the third month of the initial certification period if the member has a continued need for supplemental oxygen. Re-certification will be required every 12 months.~~

~~(A) **Adults.** Initial requests for oxygen must include ABG or resting oximetry results. The arterial blood saturation can not exceed 89% at rest on room air; the pO2 level can not exceed 59mm Hg.~~

~~(B) **Children.** Requests for oxygen for children that do not meet the following requirements should include documentation of the medical necessity based on the child's clinical condition and are considered on a case-by-case basis. Members 20 years of age or less must meet~~

~~the following requirements:~~

~~(i) birth through three years, SaO2 level equal to or less than 94%; and~~

~~(ii) ages four and above, SaO2 level equal to or less than 90%.~~In addition to ABG data, the following three tests are acceptable for determining medical necessity for oxygen prescription:

(A) At rest and awake "spot oximetry."

(B) During sleep:

i. Overnight Sleep Oximetry done inpatient or at home.

ii. Polysomnogram, which may be used only if medically necessary for concurrent evaluation of another condition while in a chronic stable state.

(C) During exercise with all three of the following performed in the same testing session.

i. At rest, off oxygen showing a non-qualifying result.

ii. During exercise, off oxygen showing a qualifying event.

iii. During exercise, on oxygen showing improvement over test (C) ii above.

(3) Certification criteria:

(A) All qualifying testing must meet the following criteria:

(B) Adults. Initial requests for oxygen must include ABG or resting oximetry results. At rest and on room air, the arterial blood saturation (SaO2) cannot exceed 89% or the pO2 cannot exceed 59mm Hg.

(C) Children. Members 20 years of age or less must meet the following requirements:

(i) birth through three years, SaO2 equal to or less than 94%;or

(ii) ages four and above, SaO2 level equal to or less than 90%.

(iii)Requests from the qualified medical practitioner for oxygen for children who do not meet these requirements should include documentation of the medical necessity based on the child's clinical condition. These requests are considered on a case-by-case basis.

(b) **Certificate of medical necessity.**

(1) The ~~medical~~DMEPOS supplier must have a fully completed current CMN(CMS-484 or HCA-32 must be used for members 20 years of age and younger) on file to support the claims for oxygen or oxygen supplies, and to establish whether coverage criteria are met and to ensure that the oxygen services provided are consistent with the physician's prescription (refer to instructions from Palmetto Government Benefits Administration, the Oklahoma Medicare Carrier, for further

requirements for completion of the CMN).

(2) ~~The CMN must be signed by the physician prior to submitting the initial claim. When a physician prescription for oxygen is renewed, a CMN, including the required retesting, must be completed by the physician prior to the submission of claims. The medical and prescription information on the CMN may be completed by a non physician clinician, or an employee of the physician for the physician's review and signature. In situations where the physician has prescribed oxygen over the phone, it is acceptable to have a cover letter containing the same information as the CMN, stating the physician's orders, as long as the CMN has been signed by the physician or as set out above.~~ The CMN must be signed by the qualified medical practitioner prior to submitting the initial claim. If a verbal order containing qualifying data is received by the DME provider, oxygen and supplies may be dispensed using the verbal order date as the billing date. The CMN initial date, the verbal order date, and the date of delivery should be the same date. It is acceptable to have a cover letter containing the same information as the CMN, stating the qualified medical practitioner's orders. The CMN signed by the qualified medical practitioner must be attached to the PAR.

(3) ~~Prescription for oxygen services must be updated at least annually and at any time a change in prescription occurs during the year. All DMEPOS suppliers are responsible for maintaining the prescription(s) for oxygen services and CMN in each member's file. If any change in prescription occurs, the physician must complete a new CMN that must be maintained in the member's file by the DME supplier. The OHCA or its designated agent will conduct ongoing monitoring of prescriptions for oxygen services to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.~~ The medical and prescription information on the CMN may be completed by a non-physician clinician, or an employee, for the qualified medical practitioner's review and signature.

(4) When a Certificate of Medical Necessity for oxygen is recertified, a prior authorization request will be required.

(5) Re-certification and related retesting will be required every 12 months.

(6) CMN for oxygen services must be updated at least annually and at any time a change in prescription occurs during the year. All DMEPOS suppliers are responsible for maintaining the prescription(s) for oxygen services and CMN in each member's file.

(7) The OHCA or its designated agent will conduct ongoing monitoring of prescriptions for oxygen services to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.

317:30-5-211.12. Oxygen rental

A monthly rental payment is made for rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators. The rental payment for a stationary system includes all contents and supplies, such as, regulators, tubing, masks, etc that are medically necessary. An additional monthly payment may be made for a portable liquid or gaseous oxygen system based on medical necessity.

(1) Oxygen concentrators are covered items for members residing in their home or in a nursing facility.

(2) For members who meet medical necessity criteria, SoonerCare covers portable liquid or gaseous oxygen systems. Portable oxygen contents are not covered for adults. The need for a portable oxygen system must be stated on the CMN. A portable system that is used as a backup system only is not a covered item.

(3) When ~~six~~four or more liters of oxygen are medically necessary, an additional payment will be paid up to 150% of the allowable for a stationary system when billed with the appropriate modifier.

317:30-5-211.16. Coverage for nursing facility residents

(a) For residents in a nursing facility, most DMEPOS are considered part of the facility's per diem rate. The following are not included in the per diem rate and may be billed by the appropriate medical supplier:

(1) Services requiring prior authorization:

(A) ventilators and supplies;

(B) total parenteral nutrition (TPN), and supplies;

(C) custom seating for wheelchairs;~~ and~~

(D) external breast prosthesis and support accessories~~.~~; and

(E) oxygen and oxygen concentrators, after the initial three months.

(i) **PRN oxygen.** Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.

(ii) **Billing for Medicare eligible nursing home members.** Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim with OHCA.

(2) Services not requiring prior authorization:

(A) permanent indwelling or male external catheters and catheter accessories;

(B) colostomy and urostomy supplies;

(C) tracheostomy supplies; and

(D) catheters and catheter accessories~~;~~.

~~(E) oxygen and oxygen concentrators.~~

~~(i) **PRN oxygen.** Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.~~

~~(ii) **Billing for Medicare eligible nursing home members.** Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim with OHCA.~~

(b) Items not covered include but are not limited to:

(1) diapers;

(2) underpads;

(3) medicine cups;

(4) eating utensils; and

(5) personal comfort items.

14-08 Limiting Reimbursement for Eyeglasses

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROIVDER POLICIES
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 other than those provided in an institution for mental diseases.

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

(B) Coverage for members under 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 free standing 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 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) Nursing facility services (other than services in an institution for tuberculosis or mental diseases).

(13) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under 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 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 317:30-3-65.4.

(A) Child health 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 visual screening and glasses each 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 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 OAC 317:30-5-278.

(J) Inpatient Psychotherapy services and psychological testing as outlined in OAC 317:30-5-95 through OAC 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 and prosthetic devices beyond the normal scope of SoonerCare.

(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 21 years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least 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 nursing facility,

~~ICF/MR~~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 per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

(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 Nurses
(G) Anesthesiologist Assistants

(17) Free-standing ambulatory surgery centers.

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

(A) unlimited medically necessary monthly prescriptions for:

(i) members under the age of 21 years; and
(ii) residents of Nursing Facilities or Intermediate Care Facilities for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities.

(B) seven medically necessary generic prescriptions per month in addition to the six covered under the State Plan are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. These additional medically necessary prescriptions beyond the two brand name or thirteen total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of durable medical equipment.

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

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

(22) Prosthetic devices 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.

(23) Standard medical supplies.

(24) Eyeglasses under EPSDT for members under age 21. Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(25) Blood and blood fractions for members when administered on an outpatient basis.

(26) Inpatient services for members age 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.

(27) Nursing facility services, limited to members preauthorized and approved by OHCA for such care.

(28) Inpatient psychiatric facility admissions for members under 21 are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.

(29) 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.

(30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last date of pregnancy.

(31) Nursing facility services for members under 21 years of age.

(32) 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 R.N.

(33) Part A deductible and Part B Medicare Coinsurance and/or deductible.

(34) Home and Community Based Waiver Services for the intellectually disabled.

(35) Home health services limited to 36 visits per year and standard supplies for 1 month in a 12-month period. The visits are limited to any combination of Registered Nurse and nurse aide visits, not to exceed 36 per year.

(36) 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) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(D) Finally, procedures considered experimental or investigational are not covered.

(37) Home and community-based waiver services for intellectually disabled members who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).

(38) Case Management services for the chronically and/or severely mentally ill.

(39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.

(40) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.

(41) Early Intervention services for children ages 0-3.

(42) Residential Behavior Management in therapeutic foster care setting.

(43) Birthing center services.

(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services.

(45) Home and Community-Based Waiver services 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 in 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.

PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM/CHILD HEALTH SERVICES

317:30-3-65.7. Vision services

(a) At a minimum, vision services include diagnosis and treatment for defects in vision, including eyeglasses once each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal (refer to OAC 317:30-5-2(b)(5) for amount, duration, and scope). Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary. The following schedule outlines the services required for vision services adopted by the OHCA.

(1) Each newborn should have an assessment of the anatomy of the lids, alignment of the eyes and clarity of the ocular media with particular attention to documenting the presence of a normal red reflex. The history should document either a normal birth or other condition such as prematurity.

(2) Red reflex and external appearance should be repeated and recorded on infants between one and four months of age.
(3) At six months of age, repeat red reflex and external exam and add an evaluation of ocular alignment with a corneal light reflex test.
(4) One screen should occur between nine and 12 months to mirror the six month screening.
(5) One screening from age three to five including alignment and an acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
(6) Objective visual acuity testing should be provided at ages five through ten, and once during ages 11 through 18. All other years are subjective by history.

(b) Interperiodic vision examinations are allowed at intervals outside the periodicity schedule when a vision condition is suspected.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 45. OPTOMETRISTS

317:30-5-432.1. Corrective lenses and optical supplies

(a) Payment will be made for children for lenses, frames, low vision aids and certain tints when medically necessary including to protect children with monocular vision. ~~Coverage includes one set of lenses and frames per year.~~ Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(b) Corrective lenses must be based on medical need. Medical need includes a change in prescription or replacement due to normal lens wear.

(c) SoonerCare provides frames when medically necessary. Frames are expected to last at least one year and must be reusable. If a lens prescription changes, the same frame must be used if possible. Payment for frames includes the dispensing fee.

(d) SoonerCare reimbursement for frames or lenses represents payment in full. No difference can be collected from the patient, family or guardians.

(e) Replacement of or additional lenses and frames are allowed when medically necessary. Prior authorization is not required~~;~~ unless the number of glasses exceeds two per year. ~~however, the~~The provider must always document in the patient record the reason for the replacement or additional eyeglasses. The OHCA or its designated agent will conduct ongoing monitoring of replacement frequencies to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.

(f) Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Progressive lenses, trifocals, photochromic lenses and tints for children require prior authorization and medical necessity. Polycarbonate lenses are

covered for children when medically necessary. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(g) Progressive lenses, aspheric lenses, tints, coatings and photochromic lenses for adults are not compensable and may be billed to the patient.

(h) Replacement of lenses and frames due to abuse and neglect by the member is not covered.

(i) Bandage contact lenses are a covered benefit for adults and children. Contact lenses for medically necessary treatment of conditions such as aphakia, keratoconus, following keratoplasty, aniseikonia/anisometropia or albinism are a covered benefit for adults and children. Other contact lenses for children require prior authorization and medical necessity.

14.09 SoonerCare Choice Enrollment Ineligibility

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE
SUBCHAPTER 7. SOONERCARE
PART 3. ENROLLMENT CRITERIA

317:25-7-13. Enrollment ineligibility

Members in certain categories are excluded from participation in the SoonerCare Choice program. All other members are enrolled in the SoonerCare Choice program and subject to the provisions of this Subchapter. Members excluded from participation in SoonerCare Choice include:

(1) Individuals receiving services in a nursing facility, in an ~~intermediate care facility for the mentally retarded (ICF-MR)~~Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or through a Home and Community Based Waiver.
(2) Individuals privately enrolled in an HMO.
(3) Individuals who would be traveling more than 45 miles or an average of 45 minutes to obtain primary care services.
(4) Children who are known to the OHCA to be in custody, as reported by the Oklahoma Department of Human Services.
(5) Individuals who are eligible for SoonerCare solely due to presumptive eligibility.
(6) Non-qualified or ineligible aliens.
(7) Children in subsidized adoptions.
(8) Individuals who are dually-eligible for SoonerCare and Medicare.
(9) Individuals who are in an Institution for Mental Disease (IMD).
(10) Individuals who have other primary medical insurance.

PART 5. ENROLLMENT PROCESS

317:25-7-28. Disenrolling a member from SoonerCare

(a) The OHCA may disenroll a member from SoonerCare if:
(1) the member is no longer eligible for SoonerCare services;
(2) the member has been incarcerated;
(3) the member dies;
(4) disenrollment is determined to be necessary by the OHCA;
(5) the status of the member changes, rendering him/her ineligible for SoonerCare;
(6) the member is already enrolled in the SoonerCare Program, when they are taken or found to be in custody as reported by the Oklahoma Department of Human Services;
(7) the member is authorized to receive services in a nursing facility, in an ~~intermediate care facility for the mentally retarded (ICF-MR)~~Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or through a Home and Community Based Waiver; ~~or~~

(8) the member becomes dually-eligible for SoonerCare and Medicare~~.~~; or

(9) the member becomes covered under other primary medical insurance.

(b) The OHCA may disenroll the member at any time if the member is disenrolled for good cause, as it is defined in OAC 317:25-7-27. The OHCA will inform the PCP of any disenrollments from his or her member roster.

(c) OHCA may disenroll a member upon the PCP's request as described in (1) through (5) of this subsection.

(1) The PCP may file a written request asking OHCA to take action including, but not limited to, disenrolling a member when the member:

(A) is physically or verbally abusive to office staff, providers and/or other patients;

(B) is habitually non-compliant with the documented medical directions of the PCP; or

(C) regularly fails to arrive for scheduled appointments without cancelling and the PCP has made all reasonable efforts to accommodate the member.

(2) The request from the PCP for disenrollment of a member must include one of more of the following:

(A) documentation of the difficulty encountered with the member including the nature, extent and frequency of abusive or harmful behavior, violence, and/or inability to treat or engage the member;

(B) identification and documentation of unique religious or cultural issues that may be effecting the PCP's ability to provide treatment effectively to the member; or

(C) documentation of special assistance or intervention offered.

(3) The PCP may not request disenrollment because of a change in the member's health status, the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs except when the member's enrollment with the PCP seriously impairs his/her ability to furnish services to this member or other members.

(4) The PCP must document efforts taken to inform the member orally or in writing of any actions that have interfered with the effective provision of covered services, as well as efforts to explain what actions or language of the member are acceptable and unacceptable and the consequences of unacceptable behavior, including disenrollment from the PCP.

(5) The OHCA will give written notice of the disenrollment request to the member.

Presentation by the Department of Mental Health and Substance Abuse Services on Proposed Cuts to Behavioral Health Services—The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and the Oklahoma Health Care Authority (OHCA) are exploring making revisions to outpatient behavioral health rules to restrict access to psychosocial rehabilitation (PSR) services to adults with Serious Mental Illness, children with Serious Emotional Disturbance and individuals suffering from acute substance use disorders. Narrowing the eligibility criteria for PSR services comports with the Federal definition of rehabilitative services found in 42 CFR 440.130(d) which defines them as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts…for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level."