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 ~~Primary Care Case Manager~~ 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 ~~Primary Care Case Manager~~ SoonerCare Choice contracts in the SoonerCare Program.

(b) **Assignment in fee-for-service.** The ~~Authority's~~ 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 copayment required by the State Plan to be paid by the ~~recipient~~ member and make no additional charges to the patient 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 This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.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 ~~patient~~ member must not be billed and the ~~patient~~ member is not responsible for any balance except the amount indicated by OHCA. The only amount a ~~patient~~ member may be responsible for is ~~the personal participation as agreed to at the time of determination of eligibility~~ a copayment, or the ~~patient~~ member may be responsible for services not covered under the medical programs. ~~The amount of personal participation will be shown on the OHCA notification of eligibility.~~ In any event, the ~~patient~~ 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, ~~Customer~~ Provider Services.

(3) When potential assignment violations are detected, the ~~Authority~~ 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 ~~Authority~~ 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 ~~Primary Care Case Management~~ SoonerCare Choice program ~~shall~~ must adhere to the rules of this subsection regarding assignment.

~~(1) If the service provided to the recipient is within the scope of the services outlined in the SoonerCare Contract, the recipient shall not be billed for the service. In this case, the provider shall pursue collection from the Primary Care Physician in the case of the SoonerCare Program.~~

~~(2)~~ (1) If the service provided to the ~~recipient~~ member is outside of the scope of the services outlined in the SoonerCare Contract, then the provider may bill or seek collection from the ~~recipient~~ member.

~~(3)~~ (2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) ~~and (2)~~ of this subsection, the Oklahoma Health Care Authority shall be the final authority for this decision. The provider seeking payment under the SoonerCare Program may appeal to OHCA under the provisions of OAC 317:2-1-2.1.

~~(4)~~ (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 ~~recipients~~ members to share some of the costs of ~~Medicaid~~ SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, copayments, or similar cost sharing charges. OHCA requires a copayment of some ~~Medicaid recipients~~ SoonerCare members for certain medical services provided through the fee for service program. A copayment is a charge which must be paid by the ~~recipient~~ member to the service provider when the service is covered by ~~Medicaid~~ SoonerCare. Section 1916(e) of the Act requires that a provider participating in the ~~Medicaid~~ SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the copayment. A person's assertion of their inability to pay the copayment establishes this inability. This rule does not change the fact that a ~~recipient~~ member is liable for these charges and it does not preclude the provider from attempting to collect the copayment.

(1) Copayment is not required of the following ~~recipients~~ members:

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

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

(C) Pregnant women.
(D) Home and Community Based ~~Waiver service recipients~~ Service waiver members except for prescription drugs.

(2) Copayment 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.

(3) Copayments required include:
(A) $3.00 per day for inpatient hospital services. Copayments for inpatient care paid under the Diagnosis Related Groups (DRG) methodology are calculated on the actual length of stay and are capped at $90. Copayments for claims paid under Level of Care methodology are calculated at $3.00 per day.
(B) $3.00 per day for outpatient hospital services.
(C) $3.00 per day for ambulatory surgery services including free-standing ambulatory surgery centers.
(D) $1.00 for each ~~service~~ visit for services rendered by the following providers:
(i) Physicians,
(ii) Advanced Practice Nurses,
(iii) Physician Assistants,
~~(ii)~~ (iv) Optometrists,
~~(iii)~~ (v) Home Health Agencies, and
~~(iv) Rural Health Clinics,~~
~~(v)~~ (vi) Certified Registered Nurse Anesthetists~~, and~~
~~(vi) Federally Qualified Health Centers~~.
(E) Prescription drugs.
(i) $1.00 for prescriptions having a ~~Medicaid~~ SoonerCare allowable of $29.99 or less.
(ii) $2.00 for prescriptions having a ~~Medicaid~~ SoonerCare allowable of $30.00 or more.
(F) Crossover claims. Dually eligible ~~Medicare/Medicaid recipients~~ Medicare/SoonerCare members must make a copayment of $.50 per ~~service~~ visit for all Part B covered services. This does not include dually eligible ~~HCBW service recipients~~ HCBS waiver members.