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

317:30-5-210.1. Coverage for adults

Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for adults is specified in OAC 317:30-5-211.1 through OAC 317:30-5-211.18.

317:30-5-210.2. Coverage for children

(a) **Coverage.** Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for children includes the specified coverage for adults found in OAC 317:30-5-211.1 through OAC 317:30-5-211.18. In addition the following are covered items for children only:

(1) Orthotics and prosthetics.

(2) Enteral nutrition is considered medically necessary for certain conditions in which, without the products, the member's condition would deteriorate to the point of severe malnutrition.

(A) Enteral nutrition must be prior authorized. PA requests must include:

(i) the member's diagnosis;

(ii) the impairment that prevents adequate nutrition by conventional means;

(iii) the member's weight history before initiating enteral nutrition that demonstrates oral intake without enteral nutrition is inadequate; and

(iv) the percentage of the member's average daily nutrition taken by mouth and by tube; and

(v) prescribed daily caloric intake.

(B) Enteral nutrition products that are administered orally and related supplies are not covered.

(b) **EPSDT.** Services deemed medically necessary and allowable under federal regulations may be covered by the EPSDT Child Health program even though those services may not be part of the SoonerCare program. These services must be prior authorized.

(c) **Medical necessity.** Federal regulations require OHCA to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or that are considered experimental.

317:30-5-211.1. Definitions

The following words and terms, when used in this Part, have the following meaning, unless the context clearly indicates otherwise.

"**Adaptive equipment**" means devices, aids, controls, appliances or supplies of either a communication or adaptive type, determined necessary to enable the person to increase his or her ability to function in a home and community based setting or private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) with independence and safety.

"**Capped rental**" means monthly payments for the use of the Durable Medical Equipment (DME) for a limited period of time not to exceed 13 months. Items are considered purchased after 13 months of continuous rental.

"**Certificate of medical necessity (CMN)**" means a certificate required to help document the medical necessity and other coverage criteria for selected items, those items are defined in this Chapter. The physician's certification must include the member's diagnosis, the reason the equipment is required, and the physician's estimate, in months, of the duration of its need.

"**Customized DME**" means items of DME which have been uniquely constructed or substantially modified for a specific member according to the description and orders of the member's treating physician. For instance, a wheelchair would be considered "customized" if it has been:

(A) measured, fitted or adapted in consideration of the member's body size, disability, period of need, or intended use;

(B) assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs; and

(C) intended for an individual member's use in accordance with instructions from the member's physician.

~~"**DME information form (DIF)**" means a document used to provide additional information needed to process a claim. The DIF is completed by the supplier and is not reviewed and signed by the physician. In the event of a post payment audit, the supplier must be able to produce the DIF and, if requested, produce information to substantiate the information on the DIF.~~

"**Durable medical equipment (DME)**" means equipment that can withstand repeated use, i.e.; the type of item that could normally be rented is used to serve a medical purpose, is not useful to a person in the absence of an

illness or injury, and is used in the most appropriate setting including the home or workplace.

"**Invoice**" means a document that provides the following information when applicable; description of product, quantity, quantity in box, purchase price (less any discounts, rebates or commissions received), NDC, strength, dosage, provider, seller's name and address, purchaser's name and address and date of purchase. At times, visit notes will be required to determine how much of the supply was expended. When possible, the provider should identify the SoonerCare member receiving the equipment or supply on the invoice.

"**Medical supplies**" means an article used in the cure, mitigation, treatment, prevention, or diagnosis of illnesses. Disposable medical supplies are medical supplies consumed in a single usage and do not include skin care creams or cleansers. Medical supplies do not include surgical supplies or medical or surgical equipment.

"**OHCA CMN**" means a certificate required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this chapter. The physician's certification must include the member's diagnosis, the reason equipment is required, and the physician's estimate, in months, of the duration of its need. This certificate is used when the OHCA requires a CMN and one has not been established by CMS.

"**Orthotics**" means an item used for the correction or prevention of skeletal deformities.

"**Prosthetic devices**" means a replacement, corrective, or supportive device (including repair and replacement parts for same) worn on or in the body, to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.

317:30-5-211.8. Coverage [REVOKED]

~~Durable medical equipment, adaptive equipment, medical supplies and prosthetic devices prescribed by the appropriate medical provider and medically necessary are covered for adults and children as set forth in coverage guidelines.~~

317:30-5-211.13. ~~Prosthetic devices~~ Prosthetics and orthotics

Coverage of prosthetics for adults is limited to (1) home dialysis equipment and supplies, (2) nerve stimulators, (3) external breast prosthesis and support

the course of a surgical procedure. ~~Prosthetic devices~~ Prosthetics prescribed by an appropriate medical provider ~~as conditioned~~ and as specified in this section are covered items for adults. There is no coverage of orthotics for adults.

~~(1) **Certificate of medical necessity.** The medical supplier must have a fully completed CMN on file for prosthetic items including Transcutaneous Electric Nerve Stimulators (TENS).~~

~~(2) **Prior authorization.** Prosthetic devices, except for cataract lenses, require prior authorization.~~

~~(3)~~ (1) **Home dialysis.** Equipment and supplies are covered items for members receiving home dialysis treatments only.

~~(4)~~ (2) **Nerve stimulators.** Payment is made for ~~rental equipment which must not exceed the purchase price, for~~ transcutaneous nerve stimulators, implanted peripheral nerve stimulators, and neuromuscular stimulators. ~~After continuous rental for 13 months, the equipment becomes the property of the OHCA to be used by the member until no longer medically necessary.~~

~~(5)~~ (3) **Breast prosthesis, bras, and prosthetic garments.**

(A) Payment is limited to:

(i) one prosthetic garment with mastectomy form every 12 months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(ii) two mastectomy bras per year; and

(iii) one silicone or equal breast prosthetic per side every 24 months; or

(iv) one foam prosthetic per side every six months.

(B) Payment will not be made for both a silicone and a foam prosthetic in the same 12 month period.

(C) Breast prostheses, bras, and prosthetic garments must be purchased from a Board Certified Mastectomy Fitter.

(D) A breast prosthesis can be replaced if:

(i) lost;

(ii) irreparably damaged (other than ordinary wear and tear); or

(iii) the member's medical condition necessitates a different type of item and the physician

provides a new prescription explaining the need for a different type of prosthesis.

(E) External breast prostheses are not covered after breast reconstruction is performed except in instances where a woman with breast cancer receives reconstructive surgery following a mastectomy, but the breast implant fails or ruptures and circumstances are such that an implant replacement is not recommended by the surgeon and/or desired by the member.

~~(6)~~ (4) **Prosthetic devices inserted during surgery**. Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

317:30-5-211.14. Nutritional support

(a) **Parenteral nutrition**. The member must require intravenous feedings to maintain weight and strength commensurate with the member's overall health status. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements.

(1) The member must have a permanent impairment. Permanence does not require a determination that there is no possibility that the member's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least three months), the test of permanence is met. Parenteral nutrition will be denied as a non-covered service in situations involving temporary impairments.

(2) The member must have a condition involving the small intestine, exocrine glands, or other conditions that significantly impair the absorption of nutrients. Coverage is also provided for a disease of the stomach and/or intestine that is a motility disorder and impairs the ability of nutrients to be transported through the GI system, and other conditions as deemed medically necessary. There must be objective medical evidence supporting the clinical diagnosis.

(3) Re-certification of parenteral nutrition will be required as medically necessary and determined by the OHCA medical staff.

(b) **Prior authorization.** A written signed and dated order must be received by the supplier before a claim is submitted to the OHCA. If the supplier bills an item

addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary.

(1) The ordering physician is expected to see the member within 30 days prior to the initial certification or required re-certification. If the physician does not see the member within this time frame, the physician must document the reason why and describe what other monitoring methods were used to evaluate the member's parenteral nutrition needs.

(2) A completed DIF must be kept on file by the supplier and made available to the OHCA on request. The initial request for prior authorization must include a copy of the DIF.

(c) **Enteral formulas.** Enteral formulas are covered for children only. See OAC ~~317:30-5-212~~ 317:30-5-210.2.

317:30-5-212. Coverage for children [REVOKED]

~~(a) **Coverage.** Coverage of Durable Medical Equipment, Adaptive Equipment, Medical Supplies and Prosthetic Devices for children is the same as for adults. In addition the following are covered items:~~

~~(1) All orthotic equipment (procedures) listed by Health Care Finance Administration Common Procedural Code System (HCPCS).~~

~~(2) Durable medical equipment, adaptive equipment, medical supplies and prosthetic devices determined to be medically necessary..~~

~~(3) Enteral nutrition is considered medically necessary for certain conditions in which, without the products, the member's condition would deteriorate to the point of severe malnutrition.~~

~~(A) Enteral nutrition must be prior authorized. PA requests must include:~~

~~(i) the member's diagnosis;~~

~~(ii) the impairment that prevents adequate nutrition by conventional means;~~

~~(iii) the member's weight history before initiating enteral nutrition that demonstrates oral intake without enteral nutrition is inadequate; and~~

~~(iv) the percentage of the member's average daily nutrition taken by mouth and by tube; and~~

~~(v) prescribed daily caloric intake.~~

~~(B) Enteral nutrition products that are administered orally and related supplies are not covered.~~

~~(b) **Prior authorization requirement.** Prior authorization is the same as adults and required for all L series HCPCS codes L5000 and above.~~

~~(c) **EPSDT.** Services deemed medically necessary and allowable under federal regulations may be covered by the EPSDT Child Health program even though those services may not be part of the SoonerCare program. These services must be prior authorized.~~

~~(d) **Medical necessity.** Federal regulations require OHCA to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or that are considered experimental.~~

317:30-5-216. Prior authorization requests

(a) **Prior authorization requirements**. Requirements vary for different types of services. Providers should refer to the service-specific sections of policy or the OHCA website for services requiring PA.

(1) **Required forms**. Form HCA-12A may be obtained at local county OKDHS offices and is available on the OHCA web site at www.okhca.org.

(2) **Certificate of medical necessity**. The prescribing provider must complete the medical necessity section of the CMN. This section cannot be completed by the supplier. The medical necessity section can be completed by any health care clinician; however, only the member's treating provider may sign the CMN. By signing the CMN, the physician is validating the completeness and accuracy of the medical necessity section. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the answers given in the medical necessity section of the CMN. These records may be requested by OHCA or its representatives to confirm concurrence between the medical records and the information submitted with the prior authorization request.

~~(3) **DIF**. The requesting supplier must complete and submit a DIF as indicated by Medicare standards unless OHCA policy indicates that a CMN or other documentation is required. By signing the DIF, the supplier is validating the information provided is complete and accurate. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the information given in the DIF.~~

(b) **Submitting prior authorization requests**. Contact information for submitting prior authorization requests may be found in the OHCA Provider Billing and Procedures Manual. An electronic version of this manual is located on the OHCA web site.

(c) **Prior authorization review**. Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed by OHCA staff to evaluate whether or not each service being requested meets SoonerCare's definition of "medical necessity" [see OAC 317:30-3-1 (f)] as well as other criteria.

(d) **Prior authorization decisions**. After the HCA-12A is processed, a notice will be issued advising whether or not the item is authorized. If authorization is issued, the notice will include an authorization number, the time period for which the device is being authorized and the appropriate procedure code.

(e) **Prior authorization does not guarantee reimbursement**. Provider status, member eligibility, and medical status on the date of service, as well as all other SoonerCare requirements, must be met before the claim is reimbursed.

(f) **Prior authorization of manually-priced items.** Manually-priced items must include documentation showing the supplier's ~~estimated cost~~ Manufacturer’s Suggested Retail Price (MSRP) of the item with the request for prior authorization. The MSRP must be listed for each item in the “billed charges” box on the HCA-12A. If an item does not have an MSRP, the provider must include a copy of the current invoice indicating the cost to the provider and a statement from the manufacturer that there is no MSRP available. Reimbursement will be determined as per OAC 317:30-5-218.