OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
February 9, 2017 at 1:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
OKC, OK

A G E N D A

Items to be presented by Ed McFall, Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the January 12, 2017 OHCA Board Meeting Minutes

Item to be presented by Becky Pasternik-Ikard, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

   a) All-Star Introduction
      - October 2016 All-Star – Canielle Preston, Health Promotion Specialist (Lisa Gifford)
      - November 2016 All-Star – Nelson Solomon, Public Information Specialist (Lisa Gifford)
      - December 2016 All-Star – Fred Mensah, Financial Manager III (Carrie Evans)

   b) Financial Update – Carrie Evans, Chief Financial Officer

   c) Medicaid Director's Update – Garth Splinter, Deputy Chief Executive Officer

   d) Legislative Update – Emily Shipley, Director of Government Relations

Item to be presented by Amy Bradt, Director of Provider Enrollment

4. Discussion Item – Provider Enrollment Update

Item to be presented by Nicole Nantois, Chief of Legal Services

5. Announcements of Conflicts of Interest Panel Recommendations for All Action Items Regarding This Board Meeting.

Item to be presented by Tywanda Cox, Chief of Federal and State Policy

6. Action Item – a) Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. The Agency Requests the Adoption of the Following Permanent Rules:

The following permanent rules HAVE previously been approved by the Board and the Governor under Emergency rulemaking. These rules HAVE NOT been revised for Permanent Rulemaking.

ODMHSAS Initiated

A. AMENDING Agency rules at OAC 317:30-5-241.2 to continue coverage for the daily and weekly limits for individual, group and family psychotherapy services. The current daily limits were reduced to four units, six units and four units respectively. In addition, weekly limits were imposed that limit

the total amount of group therapy in a week to three hours and individual and family therapy will cumulatively be limited to two hours per week. Revisions also include language that excludes therapy limitations to outpatient behavioral health services provided in a foster care setting.
ODMHSAS Budget Impact: Savings were approved during promulgation of the emergency rule; the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 16-04)

B. AMENDING Agency rules at OAC 317:30-5-281 to decrease the monthly limits of psychotherapy reimbursable by SoonerCare for independently practicing Licensed Behavioral Health Professionals. The limits were reduced to four units/sessions per month.
ODMHSAS Budget Impact: Savings were approved during promulgation of the emergency rule; the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 16-05)

<u>OHCA Initiated</u>

C. AMENDING Agency rules at OAC 317:30-5-42.17 and 317:30-5-432.1 to continue allowing SoonerCare contracted providers of vision services to be reimbursed separately for refraction in an eye exam. Previously approved revisions also specified that all non-high-index lenses must be polycarbonate. In addition, the revisions allow SoonerCare contracted suppliers of eyeglasses to be paid a fitting fee if the requirements of a fitting fee are met.
Budget Impact: Savings were approved during promulgation of the emergency rule; the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 16-02)

D. AMENDING Agency rules at OAC 317:35-5-2 and 317:35-22-2 to continue the use of the global care current procedural terminology (CPT) codes for routine obstetrical care billing, which can be used if the provider had provided care for a member for greater than one trimester.
Budget Impact: Budget neutral

(Reference APA WF # 16-15B)

The following permanent rules HAVE previously been approved by the Board and the Governor under Emergency rulemaking. These rules have been REVISED for Permanent Rulemaking.

<u>OHCA Initiated</u>

E. AMENDING Agency rules at OAC 317:30-5-2 clarified licensing provisions and contracting requirements for medical residents and clarified direct physician care visit limits. Proposed revisions removed language specific to non-licensed physicians in a training program. The revisions to the medical licensure requirements were necessary to comply with federal regulations that require all ordering or referring physicians be enrolled as participating providers. Rules regarding reimbursement for obstetrical care were amended to continue the use of the global current procedural terminology (CPT) codes for routine obstetrical care billing. The proposed revisions regarding direct physician care visit limits clarified that SoonerCare Choice members are exempt from primary care office visits limits. This proposed revision was necessary to comply with current Waiver parameters and to ensure the access to care for Choice members was not impacted. **The aforementioned changes were approved during promulgation of the emergency rule.**

The following are proposed changes not previously reviewed: Amendments to General Coverage policy clarify medical necessity requirements for molecular pathology services and identify the appropriate provider types that are allowed to order testing. The current rules outline requirements for genetic testing and proposed amendments clarify that these rules apply to all molecular pathology services. Molecular pathology and genetic testing are terms that are often used interchangeably, although molecular pathology can include a broader array of laboratory services.
Budget Impact: The proposed rules requiring medical residents to contract directly with OHCA and the reinstatement of the global CPT care codes are budget neutral.

Limiting molecular pathology services to one code per one test will result in savings to the agency which has been identified in WF #16-26.

(Reference APA WF # 16-12)

F. AMENDING Agency rules at OAC 317:30-5-22, 317:30-5-22.1, 317:30-5-226, 317:30-5-229, 317:30-5-356, and 317:30-5-664.8 to continue the use of the global care Current Procedural Terminology (CPT) codes for routine obstetrical care billing, which can be used if the provider had provided care for a member for greater than one trimester. **The aforementioned changes were approved during promulgation of the emergency rule.**

The following are proposed changes not previously reviewed: Amendments to Obstetrical policy add the term certified to the title nurse midwives to align rules with terminology used by the Oklahoma Board of Nursing. Revisions remove the requirement for providers to submit the paper form CH-17 to the OHCA as part of the prior authorization process for obtaining high risk obstetrical services. The prior authorization process is online and the form is duplicative of documentation that is now required to be submitted for approval.
Budget Impact: Budget neutral

(Reference APA WF # 16-15A)

The following permanent rules HAVE NOT previously been approved by the Board.

<u>ODMHSAS Initiated</u>

G. AMENDING Agency rules at OAC 317:30-5-95.26, 317:30-5-95.33, 317:30-5-95.34 and 317:30-5-96.3 to revise existing language to accurately reflect the total number of core active treatment hours for individuals in a Community Based Transitional (CBT) setting from four to four and a half hours. In addition, revisions clarify information regarding active treatment requirements for process group therapy if a child is admitted to the facility on a day other than the beginning of a treatment week. For example, in acute, by day three, one hour of treatment is required. By day five, two hours of treatment are required. Beginning on day seven, three hours of treatment are required each week. In residential treatment (including Psychiatric Residential Treatment Facilities (PRTF) and CBT), by day five, one hour of treatment is required. Beginning on day seven, two hours of treatment is required each week. In addition, policy amends medical necessity criteria for continued stay in an acute psychiatric setting for children to include requirements for 24 hour nursing/medical supervision. This change will help ensure appropriate level of care is being provided. Rules are also revised to update the time between treatment plan reviews. Revisions clarify that time between treatment plan reviews are at a minimum every five to nine calendar days when in acute care, 14 calendar days when in a regular PRTF, 21 calendar days in the OHCA approved longer term treatment programs or specialty PRTFs and 30 calendar days in CBT treatment programs. The extension of treatment plan reviews will allow inpatient providers additional time for response to treatment as well as ease the administrative burden without compromising quality of care. Further, rules are added to clarify that payment for Health Home transitioning services provided with an inpatient provider will be directly reimbursed to the Health

Home outside of the inpatient facility's per diem or DRG rate.
ODMHSAS Budget Impact: The rule change to add health home transitioning services has a projected total savings of $937,128 with a state share savings of $132,008 attributable to the Oklahoma Department of Mental Health and Substance Abuse Services.

(Reference APA WF # 16-14)

OHCA Initiated

H. AMENDING Agency rules at OAC 317:30-5-1027 and 317:30-5-1033 to correct the number of units authorized for personal care services. The rules currently allow for 32 units yearly; however the 32 units which are in 10 minute increments have a daily limit rather than a yearly limit. In addition, rules are updated to reflect that claims must be received within six months from the date of service. This change was inadvertently missed during a previous change to the timely filing requirements.
Budget Impact: Budget neutral

(Reference APA WF # 16-11)

I. AMENDING Agency rules at OAC 317:1-3-4 to revise the State Plan Amendment and Rate Committee (SPARC) policy. Revisions increase the SPARC officials from five persons to seven persons and allows for appointed alternates. The changes to the membership enhances our coordinated efforts with sister agencies.
Budget Impact: Budget neutral

(Reference APA WF # 16-21)

J. AMENDING Agency rules at OAC 317:10-1-1, 317:10-1-3, 317:10-1-4, 317:10-1-12, and 317:10-1-16 to replace outdated references to the Oklahoma Department of Central Services with the Office of Management and Enterprise Services. The Oklahoma Department of Central Services was consolidated under the Office of Management and Enterprise Services in 2011. Revisions also clarify that supply and non-professional services acquisitions over $5,000 must be approved by the Chief Executive Officer, Executive Staff, or designee; current rules allow for the CEO or designated associate director.
Budget Impact: Budget neutral

(Reference APA WF # 16-22)

K. AMENDING Agency rules at OAC 317:30-5-660.3, 317:30-5-661.4, 317:30-5-664.1, 317:30-5-1087, 317:30-5-1090, 317:30-5-1094, and 317:30-5-1098 to Indian Health Services, Tribal Program and Urban Indian Clinics (I/T/Us) and Federally Qualified Health Centers policy that removes the minimum 45-50 minute time requirement for outpatient behavioral health encounters. Rules are also added to indicate that behavioral health services must be billed on an appropriate claim form using appropriate Current Procedural Code (CPT) and guidelines. In addition, rules clarify that prescription drugs are now billed pursuant to the changes made to our Chapter 30 rules that adhere with federal guidelines. Those changes modified the pharmacy pricing methodology and now allow the I/T/U pharmacies to be reimbursed at the Federal Office of Management and Budget (OMB) encounter rate. Further, revisions reference a section of policy related to home health services that were changed to now require a face to face encounter prior to the ordering of services. In addition, rules are revised to replace the term telemedicine with telehealth to be more inclusive of an array of telehealth technologies that could potentially be used to deliver healthcare services to SoonerCare members.
Budget Impact: Agency staff has determined that the proposed rule may result in a budget impact for the aforementioned services when provided in a Federally Qualified Health Center. The budget impact is approximately $412,130 total dollars, $165,099 state share.

(Reference APA WF # 16-23)

L. AMENDING Agency rules at OAC 317:30-5-20 to clarify medical necessity criteria for molecular pathology services and specify which provider types can order testing. In addition, proposed Laboratory Services policy clarifies reimbursement requirements for molecular pathology tests that examine multiple genes in a single test panel. Providers must utilize a one code for one test approach to billing molecular pathology tests. If an appropriate code is not available, providers are permitted to bill one unit of an unlisted molecular pathology procedure code.
Budget Impact: A one year proposed budget savings is estimated at $50,000 total dollars; State share $20,715; Federal share $29,285.

(Reference APA WF # 16-26)

M. AMENDING Agency rules at OAC 317:30-5-42.16 and 317:30-5-546 to add language in accordance with Federal regulation that directs the ordering physician and/or qualified provider to conduct and document a face-to-face encounter with a member for the initiation of home health services. The revisions are applicable to home health services that are billed by home health agencies under Title XIX program.
Budget Impact: Budget neutral

(Reference APA WF # 16-27)

Item to be presented by Ed McFall, Chairman

7. Discussion Item – Proposed Executive Session as Recommended by the Chief of Legal Services and Authorized by the Open Meetings Act, 25 Oklahoma Statutes § 307(B)(1),(4) and (7).

   a) Discussion of Pending Class Action Litigation
   b) Discussion of Pending Eligibility Litigation
   c) Discussion of Pending Contractual Litigation

8. New Business

9. ADJOURNMENT

NEXT BOARD MEETING
March 23, 2017
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
January 12, 2017
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on January 11, 2017 at 11:30 a.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on January 10, 2017 at 8:00 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Vice-Chairman Armstrong called the meeting to order at 1:07 p.m.

BOARD MEMBERS PRESENT: Chairman McFall, Vice-Chairman Armstrong, Member Bryant, Member Case, Member Robison

BOARD MEMBERS ABSENT: Member McVay, Member Nuttle

OTHERS PRESENT:

Melanie Lawrence, OHCA
Ashley Herron, OHCA
Courtney Barrett, OHCA
David Dude, Am. Cancer Society
Maya Hamaker, Student
Tasha Black, OHCA
Josh Bouye, OHCA
Leon Bragg, OHCA
LeKenya Antwine, OHCA
Queila Omena, eCapitol
Likita Gunn, OHCA
LouAnn McFall
Mike Fogarty

OTHERS PRESENT:

Mia Smith, OHCA
Will Widman, HPE
Terry Cothran, OUCOP
Brenda Teel, Chickasaw Nation
Carmen Johnson, OHCA
Vanessa Andrade, OHCA
Jo Stainsby, OHCA
Sherris H Ososanya, OHCA
Tyler Talley, eCapitol
Shannon Wilkinson, OHCA
Tatiana Reed, OHCA
Sandra Puebla, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD DECEMBER 8, 2016.

The Board routinely reviews and approves a synopsis of all its meetings. The full-length recordings of the meetings of the Board are retained at the Board Offices and may be reviewed upon written request.

MOTION: Member Case moved for approval of the December 8, 2016 board meeting minutes as published. The motion was seconded by Member Bryant.

FOR THE MOTION: Vice Chairman Armstrong

ABSTAINED: Chairman McFall, Member Robison

BOARD MEMBERS ABSENT: Member McVay, Member Nuttle

BECKY PASTERNIK-IKARD, CHIEF EXECUTIVE OFFICER'S REPORT

Chairman McFall thanked members of provider groups, the Oklahoma Health Care Authority and his wife and family for the encouragement and support during his medical absence.

Dr. Garth Splinter spoke for Ms. Ikard during the meeting due to laryngitis. Dr. Splinter mentioned that OHCA had its budget hearing at the capitol on January 10th, being the last of five agencies to present to the House. He noted that we felt it went as well as could be expected and that we presented the SFY 2014-2017 as well as our proposed SFY 2018 budget. He stated that OHCA will present to the Senate on January 31st.

DRAFT

Carrie Evans noted that Becky's budget hearing slide deck and presentation will be posted to the OHCA website for viewing.

ITEM 3a / ALL-STAR INTRODUCTION

The following OHCA All-Star was recognized.

- September 2016 All-Star – Mary Ann Dimery, Behavioral Health Specialist (Melody Anthony presented).

ITEM 3b / FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the financial transactions through the month of November. OHCA has a positive $3.6 million state dollars and are running under budget by $5 million in program spending and $1.3 million in administration. She reported that we are over budget in drug rebates and under budget in medical refunds and stated that we will continue to monitor those. Ms. Evans predicted that we will run slightly under budget for December. For more detailed information, see Item 3b in the board packet.

ITEM 3c / MEDICAID DIRECTOR'S UPDATE
Garth Splinter, Deputy Chief Executive Officer

Dr. Splinter provided an update for November 2016 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program including Insure Oklahoma numbers. He mentioned that there is a slight growth across the board. Dr. Splinter discussed charts provided for in-state contracted providers and mentioned that the dip from September to October 2016 was due to the three year cycle for contract renewals. For more detailed information, see Item 3c in the board packet.

ITEM 3c.1 / PROGRAM EXPENDITURES PRESENTATION
Courtney Barrett, Dental Services Dentist & Melanie Lawrence, Asst. Director of Strategic Planning

Ms. Barrett began the presentation by highlighting the program expenditures project which included explaining what program expenditures are and that they wanted to determine how to make the existing process more efficient. Ms. Lawrence explained the workgroup recommendations and the process changes that streamline the process. For more detailed information, see Item 3c.1 in the board packet.

ITEM 3c.2 / CPC+ UPDATE
Melody Anthony, Deputy State Medicaid Director

Ms. Anthony explained how closing out the 2015 year of CPC and what was launched in January. This report included CPC classic regions nationally, it's primary focus for the providers and shared savings. For more detailed information, see Item 3c.2 in the board packet.

ITEM 3d / RECOGNITION OF ANATAYA RUCKER FOR THE SELECTION OF ONE OF OKLAHOMA'S TOP FORTY UNDER 40 FOR 2016
Tywanda Cox, Chief of Federal & State Policy

Ms. Cox recognized and congratulated Anataya Rucker for being selected for the Top Forty Under 40 recognition in Oklahoma.

ITEM 3e / TOP WORKPLACE RECOGNITION
Jennie Melendez, Sr. Public Information Representative

Ms. Melendez mentioned that the OHCA won the Top Workplace recognition for 2016 for a second time. She presented the employee survey overview with agency specific statistics and key measures. Ms. Melendez then presented a detailed look into the survey which included responses from employees. She noted that OHCA ranked number ten in the top thirteen that was recognized in private and government companies. For more detailed information, see Item 3e in the board packet.

ITEM 4 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS

DRAFT

Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 5a-b / Consideration and Vote of Authority for Expenditure of Funds
Tiffany Lyon, Director of Fiscal Planning & Procurement

a) Consideration and Vote of Authority for Expenditure of Funds for the Recovery Audit Contractor (RAC)

MOTION: Vice-Chairman Armstrong moved for approval of Item 5a as published. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Member Bryant, Member Case

BOARD MEMBERS ABSENT: Member McVay, Member Nuttle

b) Consideration and Vote of Authority for Expenditure of Funds for the Medicaid Management Information System (MMIS) Fiscal Agent Hewlett Packard Enterprise (HPE)

MOTION: Member Case moved for approval of Item 5b as published. The motion was seconded by Member Bryant.

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong, Member Robison

BOARD MEMBERS ABSENT: Member McVay, Member Nuttle

ITEM 6a-c / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES §5030.3.
Nancy Nesser, Pharmacy Director

a) Consideration and vote to add **Acticlate® (Doxycycline Hyclate)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

b) Consideration and vote to add **Jadenu™ (Deferasirox) and Ferriprox® (Deferiprone)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

c) Consideration and vote to add **Pancreaze® (Pancrelipase), Pertzye® (Pancrelipase), and Viokace® (Pancrelipase)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION: Member Case moved for approval of Item 6a-c as published. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong, Member Bryant

BOARD MEMBERS ABSENT: Member McVay, Member Nuttle

ITEM 7 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4) and (7).
Nicole Nantois, Chief of Legal Services

Chairman McFall entertained a motion to go into Executive Session at this time.

MOTION: Vice-Chairman Armstrong moved for approval to move into Executive Session. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Member Bryant, Member Case

BOARD MEMBERS ABSENT: Member McVay, Member Nuttle

ITEM 8 / NEW BUSINESS

DRAFT

There was no new business.

ITEM 9 / ADJOURNMENT

MOTION: Member Case moved for approval for adjournment. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong, Member Bryant

BOARD MEMBERS ABSENT: Member McVay, Member Nuttle

Meeting adjourned at 2:48 p.m., 1/12/17

NEXT BOARD MEETING
February 9, 2017
Oklahoma Health Care Authority
Oklahoma City, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _______________

*Initials:*______________

DRAFT

FINANCIAL REPORT

For the Six Months Ended December 31, 2016
Submitted to the CEO & Board

- Revenues for OHCA through December, accounting for receivables, were **$2,134,984,043** or **1.2% under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$1,969,299,944 or 1.6% under** budget.

- The state dollar budget variance through December is a **positive $4,762,173.**

- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		7.3
Administration		1.7
Revenues:		
Drug Rebate		(.9)
Taxes and Fees		(.5)
Overpayments/Settlements		(2.8)
Total FY 17 Variance	**$**	**4.8**

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
SFY 2017, For the Six Month Period Ending December 31, 2016

REVENUES	FY17 Budget YTD	FY17 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 662,276,335	$ 662,276,335	$ -	0.0%
Federal Funds	1,135,554,302	1,118,842,708	(16,711,594)	(1.5)%
Tobacco Tax Collections	25,216,168	24,710,710	(505,458)	(2.0)%
Quality of Care Collections	39,235,412	39,059,927	(175,485)	(0.4)%
Prior Year Carryover	17,518,798	17,518,798	-	0.0%
Federal Deferral - Interest	29,218	29,218	-	0.0%
Drug Rebates	146,345,195	144,214,362	(2,130,833)	(1.5)%
Medical Refunds	22,992,594	15,894,399	(7,098,195)	(30.9)%
Supplemental Hospital Offset Payment Program	100,333,768	100,333,768	-	0.0%
Other Revenues	11,881,869	12,103,819	221,949	1.9%
TOTAL REVENUES	**$ 2,161,383,659**	**$ 2,134,984,043**	**$ (26,399,615)**	**(1.2)%**

EXPENDITURES	FY17 Budget YTD	FY17 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 27,228,047**	**$ 24,885,000**	**$ 2,343,047**	**8.6%**
ADMINISTRATION - CONTRACTS	**$ 42,371,740**	**$ 39,538,789**	**$ 2,832,951**	**6.7%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	21,149,888	20,017,364	1,132,524	5.4%
Acute Fee for Service Payments:				
Hospital Services	461,257,415	460,080,907	1,176,508	0.3%
Behavioral Health	9,937,518	9,949,124	(11,606)	(0.1)%
Physicians	208,635,937	204,603,690	4,032,247	1.9%
Dentists	66,242,977	64,771,705	1,471,272	2.2%
Other Practitioners	27,473,373	27,567,445	(94,072)	(0.3)%
Home Health Care	9,736,327	8,759,333	976,994	10.0%
Lab & Radiology	22,827,934	16,489,271	6,338,663	27.8%
Medical Supplies	23,281,126	23,636,693	(355,567)	(1.5)%
Ambulatory/Clinics	89,410,183	89,095,376	314,807	0.4%
Prescription Drugs	266,088,041	264,557,846	1,530,196	0.6%
OHCA Therapeutic Foster Care	81,910	(83,082)	164,991	0.0%
Other Payments:				
Nursing Facilities	288,146,750	283,266,007	4,880,743	1.7%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	31,857,102	30,483,800	1,373,302	4.3%
Medicare Buy-In	85,891,747	82,087,104	3,804,643	4.4%
Transportation	32,765,120	32,941,547	(176,427)	(0.5)%
Money Follows the Person-OHCA	176,685	87,275	89,409	0.0%
Electonic Health Records-Incentive Payments	8,331,920	8,331,920	-	0.0%
Part D Phase-In Contribution	46,662,194	46,805,749	(143,555)	(0.3)%
Supplemental Hospital Offset Payment Program	225,679,655	225,679,655	-	0.0%
Telligen	5,138,760	5,747,425	(608,665)	(11.8)%
Total OHCA Medical Programs	**1,930,772,564**	**1,904,876,155**	**25,896,409**	**1.3%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,000,461,733**	**$ 1,969,299,944**	**$ 31,161,789**	**1.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 160,921,926**	**$ 165,684,099**	**$ 4,762,173**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2017, For the Six Month Period Ending December 31, 2016

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 20,078,315	$ 20,011,718	$ -	$ 60,951	$ -	$ 5,647	$ -
Inpatient Acute Care	538,707,677	306,245,920	243,343	1,817,856	156,124,354	870,248	73,405,956
Outpatient Acute Care	210,422,833	150,787,200	20,802	2,232,114	55,469,323	1,913,394	
Behavioral Health - Inpatient	26,710,677	5,863,763	-	141,321	13,559,097	-	7,146,496
Behavioral Health - Psychiatrist	4,612,242	4,085,361	-	-	526,881	-	-
Behavioral Health - Outpatient	8,754,318	-	-	-	-	-	8,754,318
Behaviorial Health-Health Home	18,431,041	-	-	-	-	-	18,431,041
Behavioral Health Facility- Rehab	122,671,869	-	-	-	-	31,588	122,671,869
Behavioral Health - Case Management	9,198,606	-	-	-	-	-	9,198,606
Behavioral Health - PRTF	33,571,036	-	-	-	-	-	33,571,036
Residential Behavioral Management	9,971,595	-	-	-	-	-	9,971,595
Targeted Case Management	37,640,697	-	-	-	-	-	37,640,697
Therapeutic Foster Care	(83,082)	(83,082)	-	-	-	-	-
Physicians	235,799,269	202,566,340	29,050	(13,249)	-	2,008,300	31,208,827
Dentists	64,785,582	64,766,820	-	13,876	-	4,886	-
Mid Level Practitioners	1,365,845	1,353,404	-	11,304	-	1,136	-
Other Practitioners	26,412,117	25,944,033	223,182	199,213	-	45,689	-
Home Health Care	8,766,178	8,753,353	-	6,845	-	5,980	-
Lab & Radiology	16,863,260	16,376,168	-	373,988	-	113,103	-
Medical Supplies	23,779,204	22,266,916	1,355,766	142,511	-	14,011	-
Clinic Services	88,301,154	85,310,833	-	445,411	-	81,189	2,463,722
Ambulatory Surgery Centers	3,755,141	3,698,121	-	51,786	-	5,234	-
Personal Care Services	6,097,484	-	-	-	-	-	6,097,484
Nursing Facilities	283,266,007	173,958,104	109,307,903	-	-	-	-
Transportation	32,857,677	31,595,682	1,241,159	-	-	20,837	-
GME/IME/DME	88,309,062	-	-	-	-	-	88,309,062
ICF/IID Private	30,483,800	24,923,653	5,560,148	-	-	-	-
ICF/IID Public	8,146,176	-	-	-	-	-	8,146,176
CMS Payments	128,892,853	128,484,965	407,888	-	-	-	
Prescription Drugs	270,922,102	263,357,958	-	6,364,256	-	1,199,888	-
Miscellaneous Medical Payments	83,869	83,869	-	-	-	-	-
Home and Community Based Waiver	102,476,810	-	-	-	-	-	102,476,810
Homeward Bound Waiver	41,886,395	-	-	-	-	-	41,886,395
Money Follows the Person	130,714	87,275	-	-	-	-	43,439
In-Home Support Waiver	12,869,396	-	-	-	-	-	12,869,396
ADvantage Waiver	94,220,263	-	-	-	-	-	94,220,263
Family Planning/Family Planning Waiver	2,012,682	-	-	-	-	-	2,012,682
Premium Assistance*	30,657,969	-	-	30,657,969	-	-	-
Telligen	5,747,425	5,747,425	-	-	-	-	-
Electronic Health Records Incentive Payments	8,331,920	8,331,920	-	-	-	-	-
Total Medicaid Expenditures	**$ 2,657,908,180**	**$ 1,554,517,717**	**$ 118,389,242**	**$ 42,506,155**	**$ 225,679,655**	**$ 6,321,129**	**$ 710,525,871**

* Includes $30,459,115 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2017, For the Six Month Period Ending December 31, 2016

REVENUE		FY17 Actual YTD
Revenues from Other State Agencies	$	293,367,111
Federal Funds		442,698,761
TOTAL REVENUES	**$**	**736,065,871**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	102,476,810
Money Follows the Person		43,439
Homeward Bound Waiver		41,886,395
In-Home Support Waivers		12,869,396
ADvantage Waiver		94,220,263
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		8,146,176
Personal Care		6,097,484
Residential Behavioral Management		7,153,815
Targeted Case Management		32,959,036
Total Department of Human Services		**305,852,814**
State Employees Physician Payment		
Physician Payments		31,208,827
Total State Employees Physician Payment		**31,208,827**
Education Payments		
Graduate Medical Education		50,325,402
Graduate Medical Education - Physicians Manpower Training Commission		3,212,939
Indirect Medical Education		33,086,772
Direct Medical Education		1,683,949
Total Education Payments		**88,309,062**
Office of Juvenile Affairs		
Targeted Case Management		1,321,129
Residential Behavioral Management		2,817,780
Total Office of Juvenile Affairs		**4,138,909**
Department of Mental Health		
Case Management		9,198,606
Inpatient Psychiatric Free-standing		7,146,496
Outpatient		8,754,318
Health Homes		18,431,041
Psychiatric Residential Treatment Facility		33,571,036
Rehabilitation Centers		122,671,869
Total Department of Mental Health		**199,773,367**
State Department of Health		
Children's First		930,029
Sooner Start		642,582
Early Intervention		2,221,479
Early and Periodic Screening, Diagnosis, and Treatment Clinic		370,656
Family Planning		68,430
Family Planning Waiver		1,935,921
Maternity Clinic		2,709
Total Department of Health		**6,171,808**
County Health Departments		
EPSDT Clinic		385,036
Family Planning Waiver		8,330
Total County Health Departments		**393,366**
State Department of Education		**88,509**
Public Schools		**120,513**
Medicare DRG Limit		**70,000,000**
Native American Tribal Agreements		**1,062,739**
Department of Corrections		**729,651**
JD McCarty		**2,676,304**
Total OSA Medicaid Programs	**$**	**710,525,871**
OSA Non-Medicaid Programs	**$**	**34,191,398**
Accounts Receivable from OSA	**$**	**8,651,397**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
SFY 2017, For the Six Month Period Ending December 31, 2016

REVENUES	FY 17 Revenue
SHOPP Assessment Fee	$ 100,273,849
Federal Draws	136,431,411
Interest	55,670
Penalties	4,249
State Appropriations	(15,100,000)
TOTAL REVENUES	**$ 221,665,179**

EXPENDITURES	Quarter	Quarter	FY 17 Expenditures
Program Costs:	7/1/16 - 9/30/16	10/1/16 - 12/31/16	
Hospital - Inpatient Care	76,250,540	79,873,814	$ 156,124,354
Hospital -Outpatient Care	27,213,505	28,255,818	55,469,323
Psychiatric Facilities-Inpatient	6,661,677	6,897,421	13,559,097
Rehabilitation Facilities-Inpatient	257,683	269,198	526,881
Total OHCA Program Costs	110,383,405	115,296,250	$ 225,679,655
Total Expenditures			$ 225,679,655

CASH BALANCE	$ (4,014,476)

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2017, For the Six Month Period Ending December 31, 2016

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 39,039,522	$ 39,039,522
Interest Earned	20,405	20,405
TOTAL REVENUES	**$ 39,059,927**	**$ 39,059,927**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 107,472,712	$ 42,494,711	
Eyeglasses and Dentures	139,771	55,265	
Personal Allowance Increase	1,695,420	670,369	
Coverage for Durable Medical Equipment and Supplies	1,355,766	536,070	
Coverage of Qualified Medicare Beneficiary	516,378	204,176	
Part D Phase-In	407,888	161,279	
ICF/IID Rate Adjustment	2,592,874	1,025,222	
Acute Services ICF/IID	2,967,274	1,173,260	
Non-emergency Transportation - Soonerride	1,241,159	490,754	
Total Program Costs	**$ 118,389,242**	**$ 46,811,106**	**$ 46,811,106**
Administration			
OHCA Administration Costs	$ 265,017	$ 132,508	
DHS-Ombudsmen	79,036	79,036	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 344,053**	**$ 211,544**	**$ 211,544**
Total Quality of Care Fee Costs	**$ 118,733,294**	**$ 47,022,651**	
TOTAL STATE SHARE OF COSTS			**$ 47,022,651**

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
SFY 2017, For the Six Month Period Ending December 31, 2016

REVENUES	FY 16 Carryover	FY 17 Revenue	Total Revenue
Prior Year Balance	$ 5,199,281	$ -	$ 3,102,480
State Appropriations	(2,000,000)	-	-
Tobacco Tax Collections	-	20,324,386	20,324,386
Interest Income	-	62,490	62,490
Federal Draws	246,145	19,074,557	19,074,557
TOTAL REVENUES	**$ 3,445,426**	**$ 39,461,433**	**$ 42,563,913**

EXPENDITURES		FY 16 Expenditures	FY 17 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 30,459,115	$ 30,459,115
	College Students/ESI Dental		198,854	78,627
Individual Plan				
	SoonerCare Choice		$ 58,734	$ 23,223
	Inpatient Hospital		1,812,771	716,770
	Outpatient Hospital		2,201,288	870,389
	BH - Inpatient Services-DRG		134,518	53,188
	BH -Psychiatrist		-	-
	Physicians		18,282	7,229
	Dentists		13,766	5,443
	Mid Level Practitioner		11,304	4,470
	Other Practitioners		195,740	77,396
	Home Health		5,004	1,978
	Lab and Radiology		368,236	145,600
	Medical Supplies		135,463	53,562
	Clinic Services		435,460	172,181
	Ambulatory Surgery Center		51,786	20,476
	Prescription Drugs		6,241,262	2,467,795
	Miscellaneous Medical		-	-
	Premiums Collected		-	(266,991)
Total Individual Plan			**$ 11,683,614**	**$ 4,352,710**
	College Students-Service Costs		**$ 164,572**	**$ 65,072**
Total OHCA Program Costs			**$ 42,506,155**	**$ 34,955,523**
Administrative Costs				
	Salaries	$ 32,930	$ 1,015,275	$ 1,048,204
	Operating Costs	15,971	83,557	99,528
	Health Dept-Postponing	-	-	-
	Contract - HP	294,045	1,285,031	1,579,076
Total Administrative Costs		**$ 342,946**	**$ 2,383,862**	**$ 2,726,808**
Total Expenditures				**$ 37,682,332**
NET CASH BALANCE		**$ 3,102,480**		**$ 4,881,582**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
SFY 2017, For the Six Month Period Ending December 31, 2016

REVENUES	FY 17 Revenue	State Share
Tobacco Tax Collections	$ 405,504	$ 405,504
TOTAL REVENUES	**$ 405,504**	**$ 405,504**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 5,647	$ 264	
Inpatient Hospital	870,248	40,728	
Outpatient Hospital	1,913,394	89,547	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	2,008,300	93,988	
Dentists	4,886	229	
Mid-level Practitioner	1,136	53	
Other Practitioners	45,689	2,138	
Home Health	5,980	280	
Lab & Radiology	113,103	5,293	
Medical Supplies	14,011	656	
Clinic Services	81,189	3,800	
Ambulatory Surgery Center	5,234	245	
Prescription Drugs	1,199,888	56,155	
Transportation	18,083	846	
Miscellaneous Medical	2,753	129	
Total OHCA Program Costs	**$ 6,289,541**	**$ 294,350**	
OSA DMHSAS Rehab	$ 31,588	$ 1,478	
Total Medicaid Program Costs	**$ 6,321,129**	**$ 295,829**	
TOTAL STATE SHARE OF COSTS			**$ 295,829**

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.

OHCA Board Meeting
February 9, 2017
(December 2016 Data)

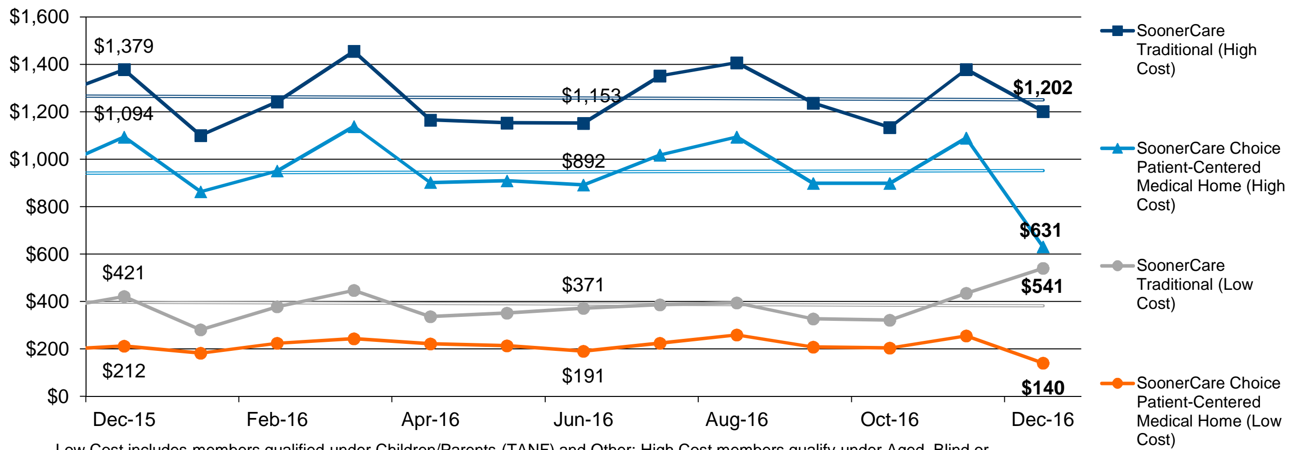
SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Enrollment December 2017	Children December 2017	Adults December 2017	Enrollment Change	Total Expenditures December	PMPM December 2017	December 2017 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**549,184**	**454,293**	**94,891**	**-12**	**$98,277,299**		
	Lower Cost	*(Children/Parents; Other)*	505,891	440,604	65,287	7	$70,937,856	$140	$208
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,293	13,689	29,604	-19	$27,339,442	$631	$884
SoonerCare Traditional			**231,228**	**86,122**	**145,106**	**-1,403**	**$199,718,378**		
	Lower Cost	*(Children/Parents; Other)*	118,375	81,098	37,277	-1,425	$64,026,211	$541	$419
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	112,853	5,024	107,829	22	$135,692,166	$1,202	$1,257
SoonerPlan			**34,058**	**2,711**	**31,347**	**-710**	**$203,701**	$6	$7
Insure Oklahoma			**20,127**	**522**	**19,605**	**236**	**$6,044,078**		
	Employer-Sponsored Insurance		15,262	335	14,927	90	$4,213,122	$276	$328
	Individual Plan		4,865	187	4,678	146	$1,830,957	$376	$399
TOTAL			**834,597**	**543,648**	**290,949**	**-1,889**	**$304,243,456**		

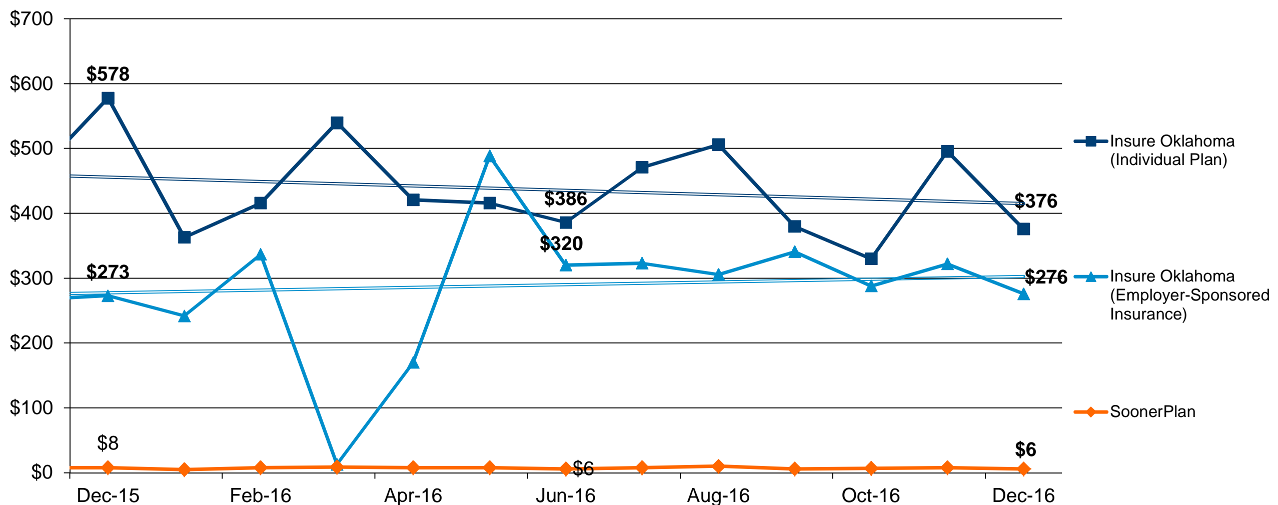
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.

Total In-State Providers: 33,370 (+502)			**(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**					
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
8,976	966	1,310	201	6,216	675	225	6,384	2,583

PER MEMBER PER MONTH COST BY GROUP



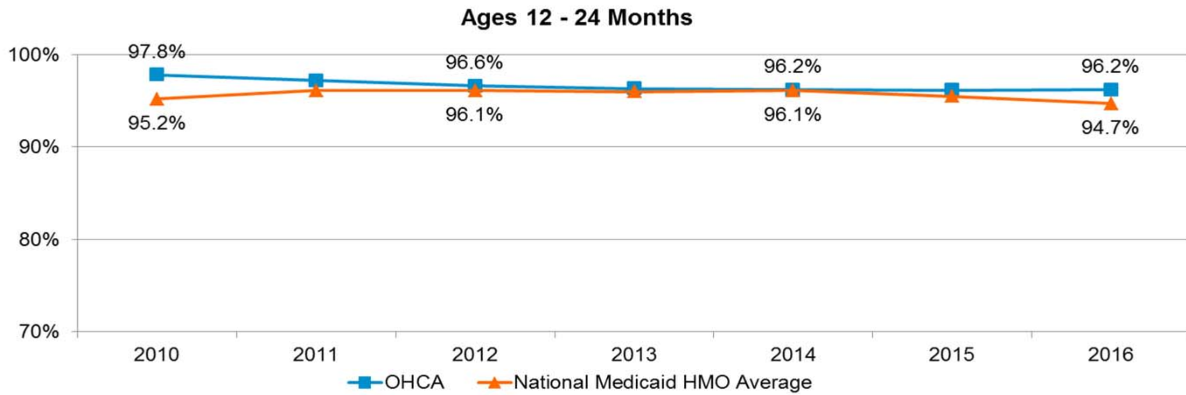
Low Cost includes members qualified under Children/Parents (TANF) and Other; High Cost members qualify under Aged, Blind or Disabled, Oklahoma Cares, TEFRA or a Home and Community-Based Services waiver.

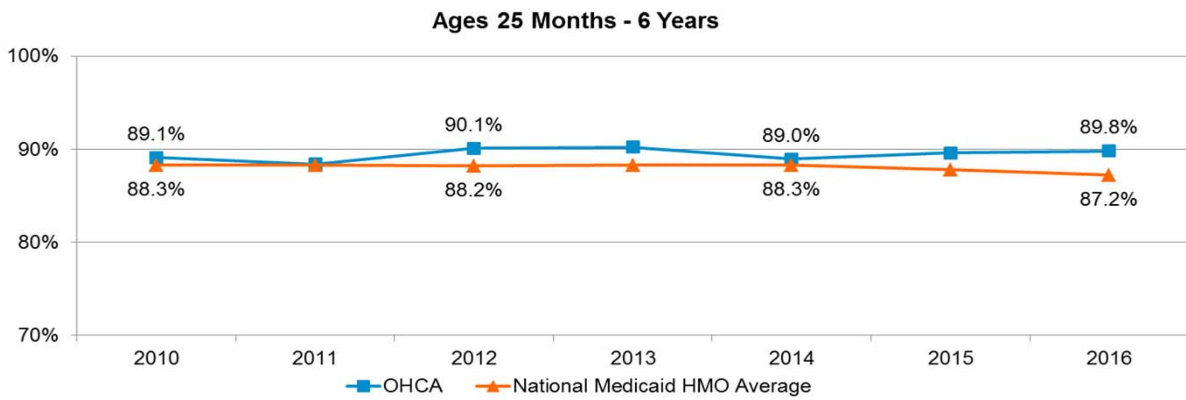


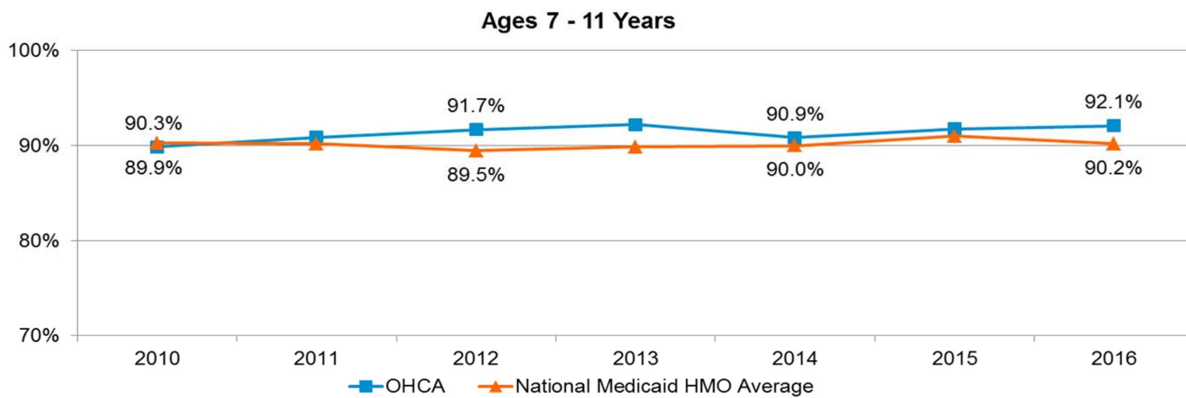
The changes in Insure Oklahoma from February to May were due to eligibility changes.

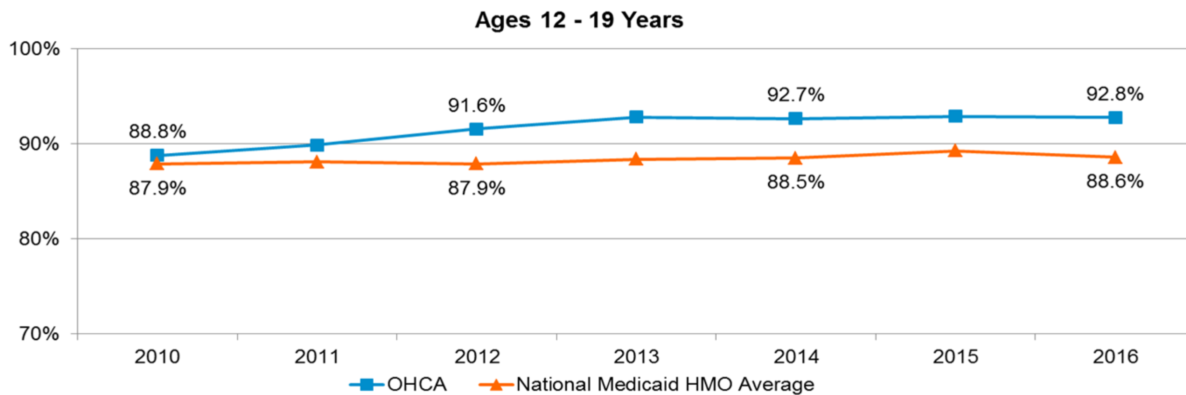
HEDIS QUALITY MEASURES - CHILDREN & ADOLESCENT'S ACCES TO PRIMARY CARE PHYSICIANS

The percentage of members 12 months to 19 years of age who had a visit with a PCP based on specific procedure codes indicating well-child visits. Children 12 months to 6 years had a PCP visit during the measurement year. Children and adolescents 7 to 19 years had a PCP visit during the current or previous measurement year. Members were continuously enrolled during the measurement year(s) with a gap in enrollment of up to 45 days allowed. Year displayed is the report year. Data is from the previous year. (2016 is report year for calendar year 2015 data, etc.).









OHCA BOARD OF DIRECTORS MEETING
LEGISLATIVE UPDATE, FEBRUARY 9, 2017

FINAL REPORT ON HOUSE BILL 2962

Passed during the 2nd regular session of the 55th Legislature, House Bill 2962 (HB 2962), authored by Representative Jason Nelson and Senator AJ Griffin, directs the Oklahoma Health Care Authority (OHCA) and partnering state agencies Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Oklahoma State Department of Education (OSDE), and the Oklahoma State Department of Health (OSDH) to study and prepare a report concentrating on the use of applied behavior analysis therapy treatment for children with ASD within the state's Medicaid program. In the last six months, the interagency workgroup has developed a comprehensive report examining the current landscape of treatment options available to ASD children through state services, the medical evidence behind ABA treatment, services offered by other states and the fiscal impact to Oklahoma if ABA treatment is included as a covered Medicaid benefit. This report was submitted to the Governor and the Oklahoma State Legislature at the end of December, 2016.

A copy of the HB 2962 Report will be included in your handout at the Board Meeting.

56th LEGISLATIVE SESSION

The Governor's State of the State address and the 1st legislative session for the 56th Legislature begins Monday, February 6 at noon.

As of January 30, 2017, the legislature has filed a total of 2,249 bills this session. OHCA is currently tracking a total of 141 bills of which six are OHCA request bills listed below.

OHCA REQUEST BILLS

- HB1579 – Rep. Chad Caldwell – Data exchange with DMV to verify member identify;
- SB0729 – Sen. Frank Simpson – Medicaid super lien;
- SB0773 – Sen. Kim David – Foster children care coordination model;
- SB0798 – Sen. Rob Standridge – Removes requirement that AG's office appoint ALJ for OHCA provider audit appeals;
- SB0819 – Sen. Frank Simpson – Property lien;
- SB0828 – Sen. A.J. Griffin – Creation of nursing home UPL revolving fund.

UPCOMING DEADLINES FOR THE 2017 LEGISLATIVE SESSION

March 2, 2017 – Senate Deadline for Senate Bills and Senate Joint Resolutions to be Reported from Senate Committee;
March 16, 2017 – Deadline for Third Reading and Final Passage of Bills and Joint Resolutions in the House of Representatives;
March 23, 2017 – Deadline for Third Reading and Final Passage of Bills and Joint Resolutions in the Senate;
April 13, 2017 – Senate Deadline for Reporting House bills and Joint Resolutions from Senate committee;
April 27, 2017 – Deadline for Third Reading of House and Senate Bills from Opposite Chamber;
Friday, May 26, 2017: Sine Die adjournment

A Legislative Bill Tracking Report will be included in your handout at the Board Meeting.

PROVIDER ENROLLMENT

Oklahoma HealthCare Authority

WHAT DOES PROVIDER ENROLLMENT DO?

- Process all SoonerCare provider contracts
- Conduct provider screenings to ensure only qualified providers are allowed to enroll
- Handle all updates to the provider file
- Assist providers with enrollment, claims denials, and contractual requirements

Oklahoma HealthCare Authority

CATEGORICAL RISK LEVELS

In 2011 the ACA required states to place providers into a categorical risk level based on the risk of fraud, waste, or abuse.

Three Levels: Limited / Moderate /High

- Cannot be in a lower category than what CMS assigned

Providers: 44,775
High Risk Providers: 1315
Moderate Risk Providers: 2665

LOW RISK PROVIDER SCREENINGS

- Licensure/Accreditation (*when applicable*)
- System for Awards Management /Excluded Parties List System
- TIBCO (PECOS: Medicare Enrollment System)
- Social Security Master Death File
- OHCA review list
- National Plan and Enumeration System (NPI)
- CMS MedFile
- Obtain disclosures regarding ownership (*when applicable*)
- Office of Inspector General

Oklahoma HealthCare Authority

MODERATE RISK PROVIDER SCREENINGS

Provider Types:

Ambulance Services, Behavioral Health Agencies, Behavioral Health Groups, Individual Behavioral Health Providers, Hospice, Independent Diagnostic Testing Facilities, Laboratories, Physical Therapy Groups, and Physical Therapists

- All low risk screenings
- Conduct on-site visits to confirm accuracy of provider's application

Oklahoma HealthCare Authority

HIGH RISK PROVIDERS

Provider Types:

DME and Home Health

- All low risk screenings
- All moderate risk screenings
- Fingerprint-based criminal background checks: owners with 5 percent or greater interest

Oklahoma HealthCare Authority

PROVIDERS MOVED TO HIGH RISK

Low and moderate risk providers must be moved into the high risk category if:

- There is an existing Medicaid overpayment (greater than $1500)
- Payment suspension within 10 years
- Terminated from any state Medicaid program within 10 years

Oklahoma HealthCare Authority

ADDITIONAL SCREENINGS

Additional screening was added to the contract applications for:

- Physicians
- Physician Assistants
- Advanced Registered Nurse Practitioners

Oklahoma HealthCare Authority

Amy Bradt
Director of Provider Enrollment
amy.bradt@okhca.org
405.522.7709

Oklahoma HealthCare Authority

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.2. Psychotherapy

(a) **Psychotherapy**.

(1) **Definition**. Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. The therapy must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities.

(2) **Interactive Complexity**. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the qualified practitioner. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the service plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) **Qualified practitioners.** Psychotherapy must be provided by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate in a setting that protects and assures confidentiality.

(4) **Limitations.** A maximum of ~~6~~four (4) units per day per member is compensable. A cumulative maximum of eight (8) units of individual psychotherapy and family psychotherapy per week per member is compensable. Except for psychotherapy involving interactive complexity as described in this Section, only the member and the qualified practitioner should be present during the session. Psychotherapy for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior Authorization Manual. Limitations do not apply to outpatient behavioral health services provided in a foster care setting.

(b) **Group Psychotherapy.**

(1) **Definition.** Group psychotherapy is a method of treating behavioral disorders using the interaction between the qualified practitioner and two or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under Behavioral Health Rehabilitation Services.

(2) **Group sizes.** Group Psychotherapy is limited to a total of eight (8) adult (18 and over) individuals except when the individuals are residents of an ICF/IID where the maximum group size is six (6). For all children under the age of ~~18~~eighteen (18), the total group size is limited to six (6).

(3) **Multi-family and conjoint family therapy.** Sessions are limited to a maximum of eight (8) families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

(4) **Qualified practitioners.** Group psychotherapy will be provided by an LBHP or Licensure Candidate. Group Psychotherapy must take place in a confidential setting limited to the qualified practitioner, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Limitations.** A maximum of ~~12~~six (6) units per day per member is compensable, not to exceed twelve (12) units per week. Group Psychotherapy is not reimbursable for a child younger than the age of three (3). Limitations do not apply to outpatient behavioral health services provided in a foster care setting.

(c) **Family Psychotherapy.**

(1) **Definition.** Family Psychotherapy is a face-to-face psychotherapeutic interaction between ~~anqualified~~ a qualified practitioner and the member's family, guardian, and/or support system. It is typically inclusive of the identified member, but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the Evidence Based Practice titled Family Psychoeducation.

(2) **Qualified practitioners.** Family Psychotherapy must be provided by an LBHP or Licensure Candidate.

(3) **Limitations.** A maximum of ~~12~~four (4) units per day per member/family unit is compensable. A cumulative maximum of eight (8) units of individual psychotherapy and family psychotherapy per week per member is compensable. The practitioner may not bill any time associated with note taking and/or medical record upkeep. The practitioner may only bill the time spent in direct face-to-face contact. Practitioner must comply with documentation requirements listed in OAC 317:30-5-248. Limitations do not apply to outpatient behavioral health services provided in a foster care setting.

(d) **Multi-Systemic Therapy (MST).**

(1) **Definition.** MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors,

and are at risk for out of home placement. Case loads are kept low due to the intensity of the services provided.

(2) **Qualified professionals.** Masters level professionals who work with a team that may include bachelor level staff.

(3) **Documentation requirements.** Providers must comply with documentation requirements in 317:30-5-248.

(4) **Service limitations.** Partial billing is not allowed, when only one service is provided in a day, providers should not bill for services performed for less than ~~8~~eight (8) minutes.

(e) **Children/Adolescent Partial Hospitalization Program (PHP).**

(1) **Definition.** Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve the member's condition and functional level and to prevent relapse or hospitalization and (3) Include the following:

(A) Assessment, diagnostic and service plan services for mental illness and/or substance use disorders provided by LBHPs or Licensure Candidates.

(B) Individual/Group/Family (primary purpose is treatment of the member's condition) psychotherapies provided by LBHPs or Licensure Candidates.

(C) Substance use disorder specific services are provided by LBHPs or Licensure Candidates qualified to provide these services.

(D) Drugs and biologicals furnished for therapeutic purposes.

(E) Family counseling, the primary purpose of which is treatment of the member's condition.

(F) Behavioral health rehabilitation services to the extent the activities are closely and clearly related to the member's care and treatment, provided by a Certified Behavioral Health Case Manager II, Certified Alcohol and Drug Counselor (CADC), LBHP, or Licensure Candidate who meets the professional requirements listed in 317:30-5-240.3.

(G) Care Coordination of behavioral health services provided by certified behavioral health case managers.

(2) **Qualified practitioners.**

(A) All services in the PHP are provided by a clinical team, consisting of the following required professionals:

(i) A licensed physician;

(ii) Registered nurse; and

(iii) One or more of the licensed behavioral health professionals (LBHP) or Licensure Candidates listed in 30-5-240.3(a) and (b).

(B) The clinical team may also include a Certified Behavioral Health Case Manager.

(C) The service plan is directed under the supervision of a physician and the number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program.

(3) **Qualified providers.** Provider agencies for PHP must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of the enrolled agency.

(4) **Limitations.** Services are limited to children 0-20 only. Children under age ~~6~~six (6) are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages ~~4~~four (4) and ~~5~~five (5) has been granted by OHCA or its designated agent based on a finding of medical necessity. Services must be offered at a minimum of ~~3~~three (3) hours per day, ~~5~~five (5) days per week. Therapeutic services are limited to ~~4~~four (4) billable hours per day. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered, those services are separately billable. Group size is limited to a maximum of ~~8~~eight (8) individuals as clinically appropriate given diagnostic and developmental functioning. Occupational, Physical and Speech therapy will be provided by the Independent School District (ISD). Academic instruction, meals, and transportation are not covered.

(5) **Service requirements.**

(A) Therapeutic Services are to include the following:

(i) Psychiatrist/physician face-to-face visit ~~2~~two (2) times per month;

(ii) Crisis management services available 24 hours a day, ~~7~~seven (7) days a week;

(B) Psychotherapies to be provided a minimum of four (4) hours per week and include the following:

(i) Individual therapy - a minimum of ~~1~~one (1) session per week;

(ii) Family therapy - a minimum of ~~1~~one (1) session per week; and

(iii) Group therapy - a minimum of ~~2~~two (2) sessions per week;

(C) Interchangeable services which include the following:

(i) Behavioral Health Case Management (face-to-face);

(ii) Behavioral health rehabilitation services/alcohol and other drug abuse education (except for children under age ~~6~~six (6), unless a prior authorization has been granted for children ages ~~4~~four (4) and ~~5~~five (5));

(iii) Medication Training and Support; and

(iv) Expressive therapy.

(6) **Documentation requirements.** Documentation needs to specify active involvement of the member's family, caretakers, or significant others involved in the individual's treatment. A nursing health assessment must be completed within 24 hours of admission. A physical examination and medical history must be coordinated with the Primary Care Physician. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to Section OAC 317:30-5-248.

(7) **Staffing requirements.** Staffing requirements must consist of the following:

(A) RN trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available onsite during program hours to provide necessary nursing care and/or psychiatric nursing care (~~1~~one (1) RN at a minimum can be backed up by an LPN but an RN must always be onsite). Nursing staff administers medications, follows up with families on medication compliance, and restraint assessments.

(B) Medical director must be a licensed psychiatrist.

(C) A psychiatrist/physician must be available 24 hours a day, ~~7~~seven (7) days a week.

(f) **Children/Adolescent Day Treatment Program.**

(1) **Definition.** Day Treatment Programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.

(2) **Qualified practitioners.** All services in Day Treatment are provided by a team, which must be composed of one or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP) or Licensure

Candidate, a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Services are directed by an LBHP or Licensure Candidate.

(3) **Qualified providers.** Provider agencies for Day Treatment must be accredited to provide Day Treatment services by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA).

(4) **Limitations.** Services must be offered at a minimum of ~~4~~four (4) days per week at least ~~3~~three (3) hours per day. Behavioral Health Rehabilitation Group size is limited to a maximum of ~~8~~eight (8) individuals as clinically appropriate given diagnostic and developmental functioning. Children under age ~~6~~six (6) are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages ~~4~~four (4) and ~~5~~five (5) has been granted by OHCA or its designated agent based on a finding of medical necessity.

(5) **Service requirements.** On-call crisis intervention services must be available 24 hours a day, ~~7~~seven (7) days a week (When members served have psychiatric needs, psychiatric services are available which include the availability of a psychiatrist 24 hours a day, ~~7~~seven (7) days a week. A psychiatrist can be available either on site or on call but must be available at all times). Day treatment program will provide assessment and diagnostic services and/or medication monitoring, when necessary.

(A) Treatment activities are to include the following every week:

(i) Family therapy at least one (1) hour per week (additional hours of FT may be substituted for other day treatment services);

(ii) Group therapy at least two (2) hours per week; and

(iii) Individual therapy at least one (1) hour per week.

(B) Additional services are to include at least one of the following services per day:

(i) Medication training and support (nursing) once monthly if on medications;

(ii) Behavioral health rehabilitation services to include alcohol and other drug education if the child meets the criteria established in 317:30-5-241.3 and is clinically necessary and appropriate (except for children under age 6, unless a prior authorization has been granted for children ages ~~4~~four (4) and ~~5~~five (5));

(iii) Behavioral health case management as needed and part of weekly hours for member;

(iv) Occupational therapy as needed and part of weekly hours for member; and

(v) Expressive therapy as needed and part of weekly hours for the member.

(6) **Documentation requirements**. Service plans are required every three (3) months.

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PART 26. LICENSED BEHAVIORAL HEALTH PROVIDERS

317:30-5-281. Coverage by Category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered as set forth in this Section, and when provided in accordance with a documented individualized service plan and/or medical record, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six (6) months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults.** ~~Coverage for adults by a~~Outpatient behavioral health coverage for adults rendered by a LBHP is limited to ~~Bio-Psycho-Social Assessments~~ bio-psycho-social assessments when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.

(1) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources,

review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.

(2) For bariatric preoperative assessments, issues to address include, but are not limited to: depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.

(c) **Children.** Coverage for children includes the following services:

(1) ~~Bio-Psycho-Social and Level of Care Assessments.~~<u>Bio-psycho-social and level of care assessments.</u>

(A) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary.

(B) Assessments for ~~Children's Level of Care~~<u>children's level of care</u> determination of medical necessity must follow a specified assessment process through OHCA or their designated agent. Only one assessment is allowable per provider per member. If there has been a break in service over a six<u> (6) </u>month period, or the assessment is conducted for the purpose of determining a child's need for inpatient psychiatric admission, then an additional unit can be authorized by OHCA, or their designated agent.

(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors

or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in an office, clinic, or other confidential setting. Group therapy is a face-to-face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six (6) for ages four (4) up to ~~18~~eighteen (18). Groups 18-20 year olds can include eight (8) individuals. Group therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight (8) family units.

(5) ~~Assessment/Evaluation~~Assessment/evaluation and testing is provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight (8) hours/units of testing per patient (over the age of three (3)), per provider is allowed every ~~12~~twelve (12) months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Test results must be reflected in the service plan or medical record. The service plan must clearly document the need for the testing and what the testing is expected to achieve. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Crisis intervention services for the purpose of stabilization and hospitalization diversion as clinically appropriate.

(7) Payment for therapy services provided by a LBHP to any one member is limited to ~~eight~~four (4) sessions/units per month. A maximum of ~~12~~twelve (12) sessions/units of therapy and testing services per day per provider are allowed. A maximum of ~~35~~thirty-five (35) hours of therapy per week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four (4) week average. Case Management services are considered an integral component of the behavioral health services listed above.

(8) A child receiving ~~Residential Behavioral Management~~residential behavioral management in a foster home, also known as therapeutic foster care, or a child receiving ~~Residential Behavioral Management~~residential behavioral management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or testing unless allowed by the OHCA or their designated agent.

(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the intellectually disabled program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

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

(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.

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PART 3. HOSPITALS

317:30-5-42.17. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage:

(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
(2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.
(3) Reversal of sterilization procedures for the purposes of conception are not covered.
(4) Medical services considered experimental or investigational.
(5) Payment for removal of benign skin lesions for adults.
(6) ~~Refractions and visual~~Visual aids.
(7) Charges incurred while the member is in a skilled nursing or swing bed.
(8) Sleep studies for adults.

PART 45. OPTOMETRISTS

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

(a) When medically necessary, payment will be made for lenses, frames, low vision aids and certain tints for children. Coverage includes lenses and frames to protect children with monocular vision. Coverage includes two sets of non-high-index polycarbonate lenses and frames per year. Any ~~high-index lenses or frames~~lenses and frames beyond this limit must be prior authorized and determined to be medically necessary. All non-high-index lenses must be polycarbonate.
(b) Corrective lenses must be based on medical need. Medical need includes a significant 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) Providers must accept ~~SoonerCare's payment~~SoonerCare reimbursement as payment in full for services rendered, except when authorized by SoonerCare (e.g., copayments, other cost sharing arrangements authorized by the State).

(1) Providers must be able to dispense standard ~~eyeglasses~~

lenses and frames which SoonerCare would fully reimburse with no cost to the eligible member.

(2) If the member wishes to select ~~eyeglasses~~lenses and frames with special features which exceed the SoonerCare allowable fee, and are not medically necessary, the member may be billed the excess cost. The provider must obtain signed consent from the member acknowledging that they are selecting ~~eyeglasses~~lenses and/or frames that will not be covered in full by SoonerCare and that they will be responsible to pay the excess cost. The signed consent must be included in the member's medical record.

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

(f) A fitting fee will be paid if there is documentation in the record that the provider or technician took measurements of the member's anatomical facial characteristics, recorded lab specifications and made final adjustment of the spectacles to the visual axes and anatomical topography. A fitting fee can only be paid in conjunction with a pair of covered lenses and frames.

~~(f)~~(g) 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 must satisfy the medical necessity standard. ~~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)~~(h) Progressive lenses, aspheric lenses, tints, coatings and photochromic lenses for adults are not compensable and may be billed to the patient.

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

~~(i)~~(j) 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 must satisfy the medical necessity standard.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-2. Categorically related programs

(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group. For individuals related to the aged, blind, or disabled groups, categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a TANF recipient, an adoption assistance or kinship guardianship assistance recipient, or is under age 19, categorical relationship is automatically established. Categorical relationship to the pregnancy group is established when the determination is made by medical evidence that the individual is or has been pregnant. Effective January 1, 2014, verification of pregnancy is only required if the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods for women in this pregnancy group; see Subchapter 22 of this Chapter for services for unborn children covered under Title XXI. For an individual age 19 or over to be related to the parent and caretaker relative group, the individual must have a minor dependent child. For an individual to be related to the former foster care children group, the individual must not be eligible for the Title XIX pregnancy or parent or caretaker relative groups, must be aged 19-26, and must have been receiving SoonerCare as a foster care child when he/she aged out of foster care in Oklahoma. There is no income or resource test for the former foster care children group. Categorical relationship to Refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer Treatment program is established in accordance with OAC 317:35-21. Categorical relationship for the SoonerPlan Family Planning Program is established in accordance with OAC 317:35-5-8. Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with OAC 317:35-22. ~~Benefits for pregnancies covered under Title XXI medical~~

~~services are provided within the limited scope of this particular program for antenatal care and delivery only. Each service must be billed using the appropriate CPT codes. To be eligible for SoonerCare benefits, an individual must be related to one of the following eligibility groups:~~Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during the prenatal, delivery and postpartum care when included in the global delivery payment. To be eligible for SoonerCare benefits, an individual must be related to one of the following eligibility groups:

(1) Aged
(2) Disabled
(3) Blind
(4) Pregnancy
(5) Children, also including
  (A) Newborns deemed eligible, and
  (B) Grandfathered CHIP children
(6) Parents and Caretaker Relatives
(7) Refugee
(8) Breast and Cervical Cancer Treatment program
(9) SoonerPlan Family Planning Program
(10) Benefits for pregnancies covered under Title XXI
(11) Former foster care children.

(b) The Authority may provide SoonerCare to reasonable categories of individuals under age 21.

(1) Individuals eligible for SoonerCare benefits include individuals between the ages of 19 and 21:
  (A) for whom a public agency is assuming full or partial financial responsibility who are in custody as reported by the Oklahoma Department of Human Services (OKDHS) and in foster homes, private institutions or public facilities; or
  (B) in adoptions subsidized in full or in part by a public agency; or
  (C) individuals under age 21 receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 21 are provided under the State Plan and the individuals are supported in full or in part by a public agency; or
(2) Individuals eligible for SoonerCare benefits include individuals between the ages of 18 and 21 if they are in custody as reported by OKDHS on their 18th birthday and living in an out of home placement.

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

317:35-22-2. Scope of coverage for Title XXI Pregnancy

(a) ~~Pregnancy related services provided are for antepartum and delivery only.~~Pregnancy related services provided are prenatal, delivery, postnatal care when included in the global delivery fee, and other related services that are medically necessary to optimize pregnancy outcomes within the defined program benefits.

(b) ~~Only two additional visits per month to other medical consultants, such as a dietitian or licensed genetic counselor for related services to evaluate and/or treat conditions that may adversely impact the fetus are covered.~~Only two visits per month for other related services to evaluate and/or treat conditions that may adversely impact the pregnancy are covered.

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CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

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PART 1. PHYSICIANS

317:30-5-2. General coverage by category

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA) SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.
(B) Inpatient psychotherapy by a physician.
(C) Inpatient psychological testing by a physician.
(D) One inpatient visit per day, per physician.
(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.
(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies.
~~(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physician s providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning. SoonerCare Choice members are exempt from the four visits per month limitation.~~
(G) Physician services on an outpatient basis include:

(i) A maximum of four primary care visits per member per month, with the exception of SoonerCare Choice members, or
(ii) A maximum of four specialty visits per member per month.
(iii) Additional visits are allowed per month for treatment related to emergency medical conditions and Family Planning services.

(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive

payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".
(I) Diagnostic x-ray and laboratory services.
(J) Mammography screening and additional follow-up mammograms as per current guidelines.
(K) Obstetrical care.
(L) Pacemakers and prostheses inserted during the course of a surgical procedure.
(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, OKDHS form 08MA016E, Authorization for Examination and Billing, must accompany the claim.
(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.
(P) Genetic counseling.
(Q) Laboratory testing.
(R) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.
(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.
(T) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met~~.~~;

(i) Attending physician performs chart review and signs off on the billed encounter;
(ii) Attending physician is present in the clinic/or hospital setting and available for consultation; and
(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

~~(U) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program~~

~~when the following conditions are met:~~

~~(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;~~

~~(ii) The contact must be documented in the medical record.~~

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

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

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

(V) The payment to a physician for medically directing the services of a CRNA or for the direct supervision of the services of an Anesthesiologist Assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

(W) Screening and follow up Pap Smears as per current guidelines.

(X) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

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

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

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

(iv) Procedures considered experimental or investigational are not covered.

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

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

(AA) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health

clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(EE) Smoking and Tobacco Use Cessation Counseling for treatment of members using tobacco.

(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:

(I) Asking the member to describe their smoking use;

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;

(IV) Assisting the member with referrals and plans to quit; and

(V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, Oklahoma State Health Department and FQHC nursing staff, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS). It is reimbursed in addition to any other appropriate ~~claims~~global payments for obstetrical care, PCP care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note that addresses the 5A's and office note signature along with the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit and not separately billable.

(FF) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

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

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

changes will impact treatment or management; and

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

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

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

(2) General coverage exclusions include the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Routine eye examinations for the sole purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of lenses, frames or visual aids.

(E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

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

(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomies.

(I) Medical services considered experimental or investigational.

(J) Payment for more than four outpatient visits per ~~month~~member (home or office) per ~~member~~month, except ~~those~~ visits in connection with family planning~~ or~~, services related to emergency medical conditions~~.~~, or primary care services provided to SoonerCare Choice members.

(K) Payment for more than two nursing facility visits per month.

(L) More than one inpatient visit per day per physician.

(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
(Q) Speech and Hearing services.
(R) Mileage.
(S) A routine hospital visit on the date of discharge unless the member expired.
(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(U) Inpatient chemical dependency treatment.
(V) Fertility treatment.
(W) Payment for removal of benign skin lesions.
(X) Sleep studies.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.
(A) All residential and acute psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25,317:30-5-95.27 and 317:30-5-95.29.
(B) Out of state placements are not authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member

is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements is proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment program.** Payment is made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(F) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(G) Non-therapeutic hysterectomies.
(H) Medical Services considered experimental or investigational.
(I) More than one inpatient visit per day per physician.
(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
(K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Mileage.
(P) A routine hospital visit on date of discharge unless the member expired.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment and within one year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment and within one year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for the denial.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-22. Obstetrical care

~~(a) Providers of obstetrical services must bill each antepartum visit separately, utilizing the appropriate evaluation and management service code. The OHCA does not recognize the codes for "global obstetrical care" which bundle these services under a single procedure code. Delivery only and postpartum care services are also billed separately by the rendering provider.~~
~~(b) The following routine obstetrical services are covered as detailed below:~~
(a) Obstetrical (OB) care is billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery is used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total obstetrical care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the antepartum visits. The antepartum care during the prenatal care period includes all care by the OB attending physician except major illness distinctly unrelated to the pregnancy.
(b) Procedures paid separately from total obstetrical care are listed in (1) - (8) of this subsection.

(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form or form covering same elements as ACOG and the most recent version of the Oklahoma Health Care Authority's Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one assessment per provider and no more than two per pregnancy.

(2) Medically necessary real time antepartum diagnostic ultrasounds will be paid in addition to antepartum care, delivery and postpartum obstetrical care under defined circumstances. To be eligible for payment, all ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).

(A) One abdominal or vaginal ultrasound will be covered in

the first trimester of pregnancy. The ultrasound must be performed by a Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Certified Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in obstetrical ultrasonography.

(B) One ultrasound after the first trimester will be covered. This ultrasound must be performed by a Board Eligible/Board Certified ~~Obstetrician-Gynecologist (OB-GYN)~~OB-GYN, Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Certified Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification in obstetrical ultrasonography.

(C) One additional detailed ultrasound is allowed by a Board Eligible/Board Certified Maternal Fetal Specialist or general obstetrician with documented specialty training in performing detailed ultrasounds. This additional ultrasound is allowed to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.

(3) Standby attendance at Cesarean Section (C-Section), for the purpose of attending the baby, is compensable when billed by a physician or qualified health care provider not participating in the delivery.

(4) Anesthesia administered by the attending physician is a compensable service and may be billed separately from the delivery.

(5) Amniocentesis is not included in routine obstetrical care and is billed separately. Payment may be made for an evaluation and management service and a medically indicated amniocentesis on the same date of service. This is an exception to general information regarding surgery found at OAC 317:30-5-8.

(6) Additional payment is not made for the delivery of multiple gestations. If one fetus is delivered vaginally and additional fetus(es)are delivered by C-section by the same physician, the higher level procedure is paid. If one fetus is delivered vaginally and additional fetus(es)are delivered by C-Section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment is not made to the same physician for both standby and assistant at C-Section.

(7) Reimbursement is allowed for nutritional counseling in a group setting for members with gestational diabetes. Refer to

OAC 317:30-5-1076(5).

(c) Assistant surgeons are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at C-Section ~~may~~ bill separately for the ~~antenatal~~prenatal and the six weeks postpartum office ~~visits~~visit.

(d) Procedures listed in (1) - (5) of this subsection are not ~~separately reimbursable~~ paid or not covered separately from total obstetrical care.

(1) Non stress test, unless the pregnancy is determined medically high risk. See OAC 317:30-5-22.1.

(2) Standby at C-Section is not compensable when billed by a physician participating in delivery.

(3) Payment is not made for an assistant surgeon for obstetrical procedures that include prenatal or postpartum care.

~~(3)~~(4) An additional allowance is not made for induction of labor, double set-up examinations, fetal stress tests, or pudendal anesthetic. Providers must not bill separately for these procedures.

~~(4)~~(5) Fetal scalp blood sampling is considered part of ~~DRG reimbursement~~the total OB care.

(e) Obstetrical coverage for children is the same as for adults. Additional procedures may be covered under EPSDT provisions if determined to be medically necessary.

(1) Services deemed medically necessary and allowable under federal Medicaid regulations are covered by the EPSDT/OHCA Child Health Program even though those services may not be part of the Oklahoma Health Care Authority SoonerCare program. Such services must be prior authorized.

(2) Federal Medicaid regulations also require the State 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 which are considered experimental.

317:30-5-22.1. Enhanced services for medically high risk pregnancies

(a) **Enhanced services.** Enhanced services are available for pregnant women eligible for SoonerCare and are in addition to services for uncomplicated maternity cases. Women deemed high risk based on criteria established by the OHCA must receive prior authorization for medically necessary enhanced benefits which include:

(1) prenatal at risk antepartum management;

(2) a combined maximum of five fetal non stress test(s) and

biophysical profiles (additional units can be prior authorized for multiple fetuses)with one test per week beginning at 32 weeks gestation and continuing to 38 weeks; and

(3) a maximum of three follow-up ultrasounds not covered under OAC 317:30-5-22(b)(2).

(b) **Prior authorization.** To receive enhanced services, the following documentation must be received by the OHCA Medical Authorizations Unit for review and approval:

(1) ACOG or other comparable comprehensive prenatal assessment; and

~~(2) chart note identifying and detailing the qualifying high risk condition;and~~

~~(3) an OHCA High Risk OB Treatment Plan/Prior Authorization Request (CH-17) signed by a Board Eligible/Board Certified Maternal Fetal Medicine (MFM) specialist, or Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN).~~

(2) appropriate documentation supporting medical necessity from a Board Eligible/Board Certified Maternal Fetal Medicine (MFM) specialist, or Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN). The documentation must include information identifying and detailing the qualifying high risk condition.

(c) **Reimbursement.** When prior authorized, enhanced benefits will be reimbursed as follows:

(1) Antepartum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request authorization of the antepartum management fee, the ~~OHCA CH-17~~treatment plan must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk antepartum management is not made during an in-patient hospital stay.

(2) Non stress tests, biophysical profiles and ultrasounds [in addition to those covered under OAC 317:30-5-22(a)(2) subparagraphs (A) through (C)] are reimbursed when prior authorized.

(3) Reimbursement for enhanced at risk antepartum management is not available to physicians who already qualify for enhanced reimbursement as state employed physicians.

PART 19. CERTIFIED NURSE MIDWIVES

317:30-5-226. Coverage by category

(a) **Adults~~ and children 21 and under~~.** Payment is made for certified nurse midwife services within the scope of practice as

defined by state law including obstetrical care such as antepartum care, delivery, postpartum care, and care of the normal newborn during the first 28 days of life.~~ Obstetrical care should be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered. Ultrasounds and other procedures for obstetrical care are paid in accordance with OAC 317:30-5-22(b).~~

(1) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care. Ultrasounds and other procedures reimbursed separately from total obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b).

(2) For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

(b) **Newborn.** Payment to certified nurse midwives for services to newborn is the same as for adults~~ and children under 21~~. A newborn is an infant during the first 28 days following birth.

(1) Providers must use OKDHS Form FSS-NB-1, or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth. A claim may then be filed for charges for the baby under the case number and the baby's name and assigned person code.

(2) Charges billed on the mother's person code for services rendered to the child will be denied.

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

317:30-5-229. Reimbursement

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

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

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

(3) Providers must use OKDHS Form FSS-NB-1 or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth.

(4) ~~Obstetrical care should be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered.~~Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

PART 35. RURAL HEALTH CLINICS

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 made for one encounter per member per day. Payment is also limited to four visits per member per month. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-65.2 for exceptions to the four visit 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, certified 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, certified 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 SoonerCare program for each prenatal visit using the appropriate CPT code 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).~~ 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.)

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.8. Obstetrical care provided by Health Centers

(a) **Billing written agreement.** In order to avoid duplicative billing situations, a Health Center must have a written agreement with its physician, certified nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how obstetrical care will be billed. The agreement must specifically identify the service provider's compensation for Health Center core services and other health services that may be provided by the Center.

(b) **Prenatal or postpartum services.**

(1) If the Health Center compensates the physician, certified nurse midwife or advanced practice nurse for the provision of obstetrical care, then the Health Center bills the OHCA for each prenatal and postpartum visit separately using the appropriate CPT evaluation and management code(s) as provided in the Health Center billing manual.

(2) ~~If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the SoonerCare program for each prenatal visit using the appropriate CPT code 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).~~ If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must bill the OHCA for prenatal care according to the global method described in the SoonerCare Traditional provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).

(3) 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.

(c) **Delivery services.** Delivery services are billed using the appropriate CPT codes for delivery. If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must be individually enrolled and bill for

those services using his or her assigned provider number. The costs associated with the delivery must be excluded from the cost settlement/encounter rate setting process ~~(see OAC 317:300-5-664.11)~~<u>(see OAC 317:30-5-664.11)</u>.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

317:30-5-1027. Billing

(a) Each service has a specified unit of service (unit) for billing purposes which represents the actual time spent providing a direct service. Direct service must be face-to face with the child. There is no reimbursement for time reviewing/completing paperwork and/or documentation related to the service or for staff travel to/from the site of service, unless otherwise specified.

(1) Most units of service are time-based, meaning that the service must be of a minimum duration in order to be billed. A unit of service that is time-based is continuous minutes; the time cannot be aggregated throughout the day.

(2) There are no minimum time requirements for evaluation services, for which the unit of service is generally a completed evaluation. The only exception is the Psychological Evaluation, which is billed in hourly increments.

(b) The following units of service are billed on the appropriate claim form:

(1) Service: Child Health Screening; Unit: Completed comprehensive screening.

(2) Service: Interperiodic Child Health Screening; Unit: Completed interperiodic screening.

(3) Service: Child Health Encounter; Unit: per encounter; limited to 3 encounters per day.

(4) Service: Individual Treatment Encounter; Unit: 15 minutes, unless otherwise specified.

(A) Hearing and Vision Services.

(B) Speech Language Therapy; Unit: per session, limited to one per day.

(C) Physical Therapy.

(D) Occupational Therapy.

(E) Nursing Services; Unit: up to 15 minutes; maximum 32 units per day.

(F) Psychotherapy Services; maximum 8 units per day.

(G) Assistive Technology.

(H) Therapeutic Behavioral Services.

(5) Service: Group Treatment Encounter; no more than 5 members per group, Unit: 15 minutes, unless otherwise specified. A daily log/list must be maintained and must identify the SoonerCare participants for each group therapy session.

(A) Hearing and Vision Services.
(B) Speech Language Therapy; Unit: per session, limited to one per day.
(C) Physical Therapy.
(D) Occupational Therapy.
(E) Psychotherapy Services; maximum 8 units per day.

(6) Service: Administration only, Immunization; Unit: one administration.
(7) Service: Hearing Evaluation; Unit: Completed Evaluation.
(8) Service: Hearing Aid Evaluation; Unit: Completed Evaluation.
(9) Service: Audiometric Test (Impedance); Unit: Completed Test (Both Ears).
(10) Service: Tympanometry and acoustic reflexes.
(11) Service: Ear Impression Mold; Unit: 2 molds (one per ear).
(12) Service: Vision Screening; Unit: one examination, by state licensed O.D., M.D., or D.O.
(13) Service: Speech Language Evaluation; Unit: one evaluation.
(14) Service: Physical Therapy Evaluation; Unit: one evaluation.
(15) Service: Occupational Therapy Evaluation; Unit: one evaluation.
(16) Service: Psychological Evaluation and Testing; Unit: one hour.
(17) Service: Personal Care Services; Unit: 10 minutes, 32 units ~~yearly~~daily.
(18) Service: Nursing Assessment/Evaluation (Acute episodic care); Unit: one assessment/evaluation, 18 yearly.
(19) Service: Psychological Evaluation and Testing; Unit: per hour of psychologist time, 8 hours yearly.

PART 104. SCHOOL-BASED CASE MANAGEMENT SERVICES

317:30-5-1033. Billing

Claims should not be submitted until SoonerCare eligibility of the individual has been determined. However, a claim must be received by OHCA within ~~12~~six (6) months of the date of service. If the eligibility of the individual has not been determined after ~~10~~four (4) months from the date of service, a claim should be submitted in order to assure that the claim is filed and reimbursement can be made should the individual be determined eligible at a later date.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95.26. Medical necessity criteria for continued stay - acute psychiatric admission for children

For continued stay acute psychiatric admissions for children must meet all of the conditions set forth in (1) to ~~(4)~~ (5) of this subsection.

(1) A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying diagnosis, children 18-20 years of age may have a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary diagnosis.

(2) Patient continues to manifest a severity of illness that requires an acute level of care as defined in the admission criteria and which could not be provided in a less restrictive setting.

(A) Documentation of regression is measured in behavioral terms.

(B) If condition is unchanged, evidence of re-evaluation of treatment objectives and therapeutic interventions.

(3) Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).

(4) Documented efforts of working with the child's family, legal guardians and/or custodians and other human service agencies toward a tentative discharge date.

(5) Requires secure 24-hour nursing/medical supervision as evidenced by:

(A) Stabilization of acute psychiatric symptoms;

(B) Need for extensive treatment under the direction of a physician; and

(C) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

317:30-5-95.33. Individual plan of care for children

(a) The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Licensed Behavioral Health Professional (LBHP)"** means

licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and advanced practice nurses (APN).

(2) **"Licensure Candidate"** means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(A) Psychology,
(B) Social Work (clinical specialty only),
(C) Professional Counselor,
(D) Marriage and Family Therapist,
(E) Behavioral Practitioner, or
(F) Alcohol and Drug Counselor.

(3) **"Individual plan of Care (IPC)"** means a written plan developed for each member within four calendar days of any admission to an acute psychiatric facility or a PRTF and is the document that directs the care and treatment of that member. In Community Based Transitional RTC, the IPC must be completed within 7 days. The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:

(A) A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. Children 18-20 years of age may have a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary diagnosis.

(B) the current functional level of the individual;

(C) treatment goals and measurable time limited objectives;

(D) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the member;

(E) plans for continuing care, including review and modification to the plan of care; and

(F) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.

(b) The individual plan of care:

(1) must be based on a diagnostic evaluation that includes

examination of the medical, psychological, social, behavioral and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;
(2) must be developed by a team of professionals as specified in OAC 317:30-5-95.35 in collaboration with the member, and his/her parents for members under the age of 18, legal guardians, or others in whose care he/she will be released after discharge;
(3) must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goal must be appropriate to the member's age, culture, strengths, needs, abilities, preferences and limitations;
(4) must establish measurable and time limited treatment objectives that reflect the expectations of the member served and parent/legal guardian (when applicable) as well as being age, developmentally and culturally appropriate. When modifications are being made to accommodate age, developmental level or a cultural issue, the documentation must be reflected on the individual plan of care. The treatment objectives must be achievable and understandable to the member and the parent/guardian (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;
(5) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;
(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into their family, school, and community;
~~(7) must be reviewed every five to nine calendar days when in acute care and a regular PRTF, every 11 to 16 calendar days in the OHCA approved longer term treatment programs or specialty PRTF and every 30 days in Community Based Transitional treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;~~
(7) must be reviewed at a minimum every five (5) to nine (9) calendar days when in acute care, every fourteen (14) calendar days when in a regular PRTF, every twenty (21) calendar days when in an OHCA approved longer term treatment program or specialty PRTFs, and every thirty (30) calendar

days in Community Based Transitional treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,

(9) each individual plan of care and plan of care review must be clearly identified as such and be signed and dated individually by the physician, LBHP or licensure candidate, member, parent/guardian (for members under the age of 18), registered nurse, and other required team members. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill or the member's acuity level precludes him/her from signing. If the member is too physically ill or the member's acuity level precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his/her condition improves but before discharge. The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature. Individual plans of care and individual plan of care reviews are not valid until completed and appropriately signed and dated. All requirements for the individual plan of care or individual plan of care reviews must be met or a partial per diem recoupment will be merited. If the member's parent/guardian is unable to sign the IPC or IPC review on the date it is completed, then within 72 hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/guardian must be included in the clinical file. In those instances where it is necessary to mail or fax an IPC or IPC review to a parent or ~~OKDHS/OJA~~Oklahoma Department of Human Services/Office of Juvenile Affairs (OKDHS/OJA) worker for review, the parent and/or OKDHS/OJA worker may fax back their signature. The provider must obtain the original signature for the clinical file within 30 days. Stamped or photocopied signatures are not allowed for any parent or member of the treatment team.

317:30-5-95.34. Active treatment for children

(a) The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Discharge/Transition Planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the patient's potential needs at the time of admission and continues throughout the patient's stay. Active collaboration with the patient, family and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the wraparound process through Systems of Care, counseling, case management and other supports in their community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.

(2) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (ROPES), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(3) **"Family therapy"** means interaction between an LBHP or licensure candidate, member and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.

(4) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living.

(5) **"Individual rehabilitative treatment"** means a face to face, one on one interaction which is performed to assist members who are experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform activities of daily living.

(6) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face to face, one on one interaction between an LBHP or licensure candidate and a member to promote emotional or psychological change to alleviate disorders.

(7) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between an LBHP or licensure candidate as defined in OAC 317:30-5-240.3, and two or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "Active Treatment". Active Treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. Families and/or guardians must

be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well documented in the member's treatment plan. For individuals in the age range of 18 up to 21, it is understood that family members and guardians will not always be involved in the member's treatment. Active Treatment also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician. Evidence based practices such as trauma informed methodology should be utilized to minimize the use of seclusion and restraint.

(c) For individuals age 18 up to 21, the Active Treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and individual plan of care must be recovery focused, trauma informed, specific to culture, age and gender, and provided face-to-face. Services, including type and frequency, will be specified in the Individual Plan of Care.

(d) For individuals under age 18, the components of Active Treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age, and gender. Individuals in acute care must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours being dedicated to core services as described in (1) below. Individuals in PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services as described in (1) below. Individuals in Community Based Transitional (CBT) must receive ten (10) hours of documented active treatment services each week, with ~~4~~four and a half (4.5) of those hours being dedicated to core services as described in (1) below. The remainder of the active treatment services may include any or all of the elective services listed in (2) below or additional hours of any of the core services. Sixty minutes is the expectation to equal one hour of treatment. When appropriate to meet the needs of the child, the 60 minute timeframe may be split into sessions of no less than 15 minutes each on the condition that the Active Treatment requirements are fully met by the end of the treatment week. The following components meet the minimum standards required for Active Treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) **Core Services.**

(A) **Individual treatment provided by the physician.** Individual treatment provided by the physician is required three times per week for acute care and one time a week in Residential Treatment Facilities. Individual treatment provided by the physician will never exceed ten calendar days between sessions in PRTFs, never exceed seven calendar days in a specialty PRTF and never exceed 30 calendar days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.

(B) **Individual therapy.** LBHPs or licensure candidates performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal directed utilizing techniques appropriate to the individual member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two hours per week in acute care and one hour per week in residential treatment by an LBHP or licensure candidate as described in OAC 317:30-5-240.3. One hour of family therapy may be substituted for one hour of individual therapy at the treatment team's discretion.

(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one hour per week for acute care and residential. One hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by an LBHP or licensure candidate as described in OAC 317:30-5-240.3.

(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three hours per week in acute care and two hours per week in residential treatment by an

LBHP or licensure candidate as defined in OAC 317:30-5-240.3. In lieu of one hour of process group therapy, one hour of expressive group therapy provided by an LBHP, licensure candidate, or Licensed Therapeutic Recreation Specialist may be substituted.

(E) **Transition/Discharge Planning.** Transition/discharge planning must be provided one hour per week in acute care and thirty minutes per week in residential and CBT. Transition/Discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

(A) **Expressive group therapy.** Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant Bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.

(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives, directly related to the individual plan of care.

(C) **Individual rehabilitative treatment.** Services will be for the reduction of psychiatric and behavioral impairment and the restoration of functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the individualized plan of care and the member's diagnosis.

(D) **Recreation therapy.** Services will be provided to reduce psychiatric and behavioral impairment as well as to restore, remediate and rehabilitate an individual's level of functioning and independence in life activities. Services will also be provided in such a way as to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in

life situations caused by an illness or disabling condition. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e. to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a Licensed Therapeutic Recreation Specialist.

(E) **Occupational therapy.** Services will be provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor and postural development. Services include therapeutic goal-directing activities and/or exercises used to improve mobility and activities of daily living (ADL) functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which they practice.

(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote good physical health. The focus of these activities should include areas such as nutrition, exercise, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects of medications have on physical health. Services can include support groups, exercise groups, and individual physical wellness plan development, implementation assistance and support.

(3) **Modifications to active treatment.** When a member is too physically ill or their acuity level precludes them from active behavioral health treatment, documentation must demonstrate that alternative clinically appropriate services were provided.

(e) The expectation is that active treatment will occur regularly throughout the treatment week. A treatment week in Acute is based on the number of days of acute service, beginning the day of admission (day 1). Required active treatment components will be based upon the length of stay as described below. A treatment week in RTC, PRTF and CBT is considered to be a calendar week (i.e. Sunday through Saturday). When a child is admitted to RTC, PRTF or CBT level of care on a day other than Sunday, or discharges on a day other than Saturday, the week will be considered a partial week and services will be required as described below. Active treatment components may include assessments/evaluations to serve as the initial individual or family session if completed by an LBHP or licensure candidate.

Start and stop time must be documented. Active treatment begins the day of admission. Days noted are calendar days.

(1) **Individual treatment provided by the physician.**

(A) In acute, by day two, 1 visit is required. By day 4, 2 visits are required. By day 7, 3 visits are required.

(B) In RTC, PRTF or CBT, one visit during admission week is required. In RTCs, 1 visit during the admission week is required, then once a week thereafter. In PRTFs, one visit during the admission week is required, then once a week thereafter. In CBT, 1 visit is required within 7 days of admission. Individual treatment provided by the physician will never exceed 10 days between sessions in PRTFs, never exceed 7 days in a specialty PRTF and never exceed 30 days in CBTs. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a History and Physical (H&P) evaluation may count as the first visit by the physician if the evaluation was personally rendered by the psychiatrist. If the member is admitted on the last day of the admission week, then the member must be seen by a physician within 24 hours of admission time.

(2) **Individual therapy.**

(A) In acute, by day 3, 30 minutes of treatment are required. By day 5, 1 hour of treatment is required. Beginning on day 7, 2 hours of treatment are required each week. This does not include admission assessments/evaluations or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(B) In residential treatment (including PRTF and CBT), by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. The treatment week is defined as Sunday through Saturday. Individual therapy may not exceed a total of 10 days between sessions. This does not include admission assessment/ evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(3) **Family therapy.**

(A) In acute, by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. This does not include admission assessments/evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessments/evaluation or Psychosocial Evaluation has not been used to substitute the initial individual therapy requirement.

(B) In residential treatment (including PRTF and CBT), by day 6, 30 minutes of treatment must be documented.

Beginning on day 7, 1 hour of treatment is required each week. This does not include admissions assessment/evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or Psychosocial Evaluation has not been used to substitute the initial individual therapy requirement. Family therapy provided by the LBHP or licensure candidate should not exceed 10 days in between sessions.

(4) Process group therapy.

(A) In acute, by day 3, 1 hour of treatment is required. By day 5, 2 hours of treatment are required. Beginning on day 7, 3 hours of treatment are required each week.

(B) In residential treatment (including PRTF and CBT), by day 5, 1 hour of treatment is required. Beginning on day 7, 2 hours of treatment are required each week.

(f) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff (RN/LPN), documentation must be in the record clearly indicating the reason, limitations, and timeframe for those services to be excused without penalty.

317:30-5-96.3. Methods of payment

(a) **Reimbursement.** Covered inpatient psychiatric and/or substance abuse services will be reimbursed using one of the following methodologies:

(1) Diagnosis Related Group (DRG);

(2) cost based; or

(3) a predetermined per diem payment.

(b) **Acute Level of Care.**

(1) Psychiatric units within general medical surgical hospitals and Critical Access hospitals. Payment will be made utilizing a DRG methodology. [See OAC 317:30-5-41(b)]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;

(2) Freestanding Psychiatric Hospitals. A predetermined statewide per diem payment will be made for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.

(c) **Residential Level of Care**

(1) **Instate Services.**

(A) Psychiatric Hospitals or Inpatient Psychiatric Programs. A pre-determined all-inclusive per diem payment will be made for routine, ancillary and professional

services. Public facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(B) Psychiatric Residential Treatment Facilities. A pre-determined per diem payment will be made to private PRTFs with 16 beds or less for routine services. All other services are separately billable. A predetermined all-inclusive per diem payment will be made for routine, ancillary and professional services to private facilities with more than 16 beds. Public facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form 2552) filed with the OHCA.

(2) **Out-of-state services.**

(A) Border and "border status" placements. Facilities are reimbursed in the same manner as in-state hospitals or PRTFs.

(B) Out-of-state placements. In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units. An incremental payment adjustment may be made for 1:1 staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges. The 1:1 staffing adjustment is limited to 60 days annually.

(d) **Health Home Transitioning Services.** Health Home services for the provision of comprehensive transitional care to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last 30 days of a covered acute or residential stay. Payment for Health Home transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to the Health Home outside of the facility's per diem or DRG rate.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 1. ADMINISTRATIVE OPERATIONS

SUBCHAPTER 3. FORMAL AND INFORMAL PROCEDURES

317:1-3-4. State Plan Amendment and Rate Committee

(a) **Definitions.** Unless the context clearly indicates otherwise, the following words and terms when used in this section are defined as follows:

(1) **Public Process** means a process as defined by federal law under ~~42.U.S.C § 1396a(A)(13)(A)~~42 U.S.C. § 1396(a)(13)A.

(2) **State Plan Amendment** means the document described in the Federal Regulations at 42 C.F.R. § 430.10.

(3) **State Plan Amendment and Rate Committee (SPARC)** means a committee comprised of administrative and executive level staff designated by the Chief Executive Officer for the Oklahoma Health Care Authority. The SPARC ~~facilities~~ facilitates the rate setting process by conducting public hearings at which the public, vendors, and OHCA staff are afforded the opportunity to provide testimony and documented evidence in support of rate recommendations. The SPARC only operates to make recommendations for changes to rates that necessitate a State Plan Amendment and/or Waiver Amendment. Rates that do not necessitate a State Plan Amendment and/or Waiver Amendment do not require a hearing.

(4) **Rate Change** means a change that affects the numerical value of payment from the Medicaid agency to the provider including the application of pre-existing factors that increase or decrease a rate. A ~~Rate Change~~rate change is not a method change. Rates found in contracts are excluded from the definition of rate change because they are set consensually in a contract. A method or methodology change, as defined below, is not a rate change.

(5) **Method Change or Methodology Change** means a change to how the rate is calculated, not the end result of the rate. In Medicaid rate setting the application of pre-existing factors many times, results in rate changes. The application of pre-existing factors, even if it results in a different rate is not a method change. A method change occurs when OHCA adds, subtracts or alters the factors used to construct the rate.

(b) **Meeting of the State Plan Amendment and Rate Committee (SPARC).** In certain instances the SPARC meets to hold public hearings regarding rates set by the Oklahoma Health Care Authority. Under certain provisions of federal law, the agency is required to hold a public hearing to gather public comment regarding proposed method changes or methodology changes regarding the rates it pays its medical providers.

(1) The SPARC only meets when a method change or methodology change occurs in a rate paid from OHCA to a medical provider.
(2) The SPARC does not meet to establish any contractually set rate to a contractor or a contractually bid rate nor does the SPARC meet to hear rate changes.

(c) **SPARC public hearing process.**
(1) The ~~five~~seven person panel conducts an open meeting under the Oklahoma Open Meetings Act.
(2) The proceedings are recorded.
(3) The panel hears agency presentations of proposals for method changes or methodology changes and considers comments of any member of the public who desires to comment upon the rate. The Chairperson controls both the agency presentation of proposals and the presentation of comments on the proposed method change.
(4) The panel votes to approve or disapprove the proposed method change in the open meeting, but may adjourn the meeting to gather further information, if necessary. The panel also may adjourn for legal advice during the proceeding. The OHCA board will vote to approve or disapprove the rate methodology upon approval by the SPARC.

(d) **Composition of the SPARC.** The Chief Executive ~~Office~~Officer appoints ~~OHCA~~ officials to serve on the SPARC. Officials may consist of OHCA employees and other state agency employees whose agencies assist in the administration of the Medicaid State Plan and/or Waiver programs. A regular alternate for each official may be approved. In such cases an official is unable to attend a committee meeting, he or she must notify the regular alternate and OHCA Chairperson.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 10. PURCHASING

317:10-1-1. Purpose

(a) The purpose of this Chapter is to describe the rules governing the contracting and purchasing requirements of the Oklahoma Health Care Authority (OHCA). The Contracts and Purchasing Divisions are internal divisions of the OHCA. These divisions provide the mechanism for the acquisition of goods, equipment, non-professional and professional services for the operation of the OHCA. These rules are superseded by the ~~Oklahoma Department of Central Services (DCS)~~Office of Management and Enterprise Services (OMES) Purchasing rules~~(OAC 580:16)~~(OAC 260:115) whenever ~~DCS~~OMES has final authority on an acquisition.

(b) Different rules apply depending on which of the above three entities is making the acquisition and whether the purchase is for professional services or non-professional services and products. When an acquisition is made by ~~DCS~~OMES, the ~~DCS~~OMES Purchasing rules at ~~OAC 580:16~~OAC 260:115 apply. When an acquisition is made by OHCA, these rules must be read in conjunction with the ~~DCS~~OMES rules.

317:10-1-3. General contracting and purchasing provisions

(a) All acquisitions made by the Oklahoma Health Care Authority shall be in accordance with the Oklahoma Central Purchasing Act, 74 Okla. Stat. §§ 85.1 et seq., other applicable statutory provisions, ~~Oklahoma Department of Central Services~~Office of Management and Enterprise Services Central Purchasing Rules and the Authority's approved internal purchasing procedures.

(b) When these rules are silent on a relevant issue related to an acquisition made by the Authority, the appropriate ~~DCS~~OMES rule applies, except that where "State Purchasing Director" is specified, this means "the Authority ~~CPO~~Certified Procurement Officer making the acquisition and/or the CEO". Where "Purchasing Division" is specified, this means "the Authority".

317:10-1-4. Vendor registration

Any vendor wishing to do business with the Authority should register on the vendor bidder list maintained by the Central Purchasing Division of the ~~Oklahoma Department of Central Services~~Office of Management and Enterprise Services. The Authority may also send solicitations by request to vendors that are not on the vendor bidder list.

317:10-1-12. Protest of award

(a) Protests of awards made by the Authority under 74 Okla.

Stat. § 85.5T are addressed at OAC 317:2-1-1 et seq.
(b) Bidders who wish to protest any other award shall follow the process outlined in the ~~Oklahoma Department of Central Services~~Office of Management and Enterprise Services rules at ~~OAC 580:16-3-21~~OAC 260:115-3-19.

317:10-1-16. Delegation of authority

The authority to procure needed products and services for the Authority has been delegated to the Authority from the ~~Oklahoma Department of Central Services~~Office of Management and Enterprise Services, Central Purchasing Division. The Authority Board delegates authority for expenditure of funds to the CEO and other Authority officers and personnel according to the dollar limits and types of products stated in (1), (2) and (3) of this Section. Within this authority, the CEO may delegate in writing to other specific individuals the responsibility for the performance of the procurement duties.

(1) **Supply and non-professional services acquisitions.** Each division director or supervisor may initiate any supply or non-professional services acquisition which is within his or her authorized division budget and approved by the ~~CEO, associate director~~CEO or designee. Any single acquisition of this kind over $5,000 up to $500,000 must be approved by the ~~CEO or a designated associate director~~CEO, Executive Staff or designee. Any single acquisition of this kind over $500,000 must be approved by the Authority Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds $500,000 for a supply or non-professional services contract must be prior approved by the ~~OHCA~~Authority Board. Any amendment to a contract that would result in a 10 percent or greater increase in the total acquisition cost originally approved by the OHCA Board must be submitted to the OHCA Board for prior approval.

(2) **Professional service contracts.** Acquisitions of professional services must be approved by the CEO or designee. All professional service contracts over $125,000 must be approved by the Authority Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds $125,000 for a professional service contract must be prior approved by the ~~OHCA~~Authority Board. Any amendment to a contract that would result in a 25 percent or greater increase or a $250,000 or greater increase in the total acquisition cost originally approved by the ~~OHCA~~Authority Board must be submitted to the ~~OHCA~~Authority Board for prior approval. Board approval is not required if the increase in total

contract acquisition cost results from the exercise of a price increase methodology, option for additional work, or option to renew that was contained in the previously approved contract.

(3) **Interagency/intergovernmental agreements.** All agreements with another state agency or public agency must be approved by the CEO or designee, but are exempt from the Authority Board approval.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-660.3. Health Center enrollment requirements for specialty behavioral health services

(a) For the provision of behavioral health related case management services and psychosocial rehabilitation services, Health Centers must contract as an outpatient behavioral health agency and meet the requirements found at OAC ~~317:30-5-240 through 317:30-5-249.~~317:30-5-241.3 and 317:30-5-241.6.

(b) Health Centers which provide substance ~~abuse~~use treatment services must also be certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

317:30-5-661.4. Behavioral health professional services provided at Health Centers and other settings

(a) Medically necessary behavioral health services that are primary, preventive, and therapeutic and that would be covered if provided in another setting may be provided by Health Centers. Services provided by a Health Center (refer to OAC ~~317:30-5-240.3~~317:30-5-241 for a description of services) must meet the same requirements as services provided by other behavioral health providers. Rendering providers must be eligible to individually enroll or meet the requirements as an agency/organization provider specified in OAC 317:30-5-240.2 and 317:30-5-280. Behavioral Health Services include:

(1) Assessment/Evaluation;
(2) Crisis Intervention Services;
(3) Individual/Interactive Psychotherapy;
(4) Group Psychotherapy;
(5) Family Psychotherapy;
(6) Psychological Testing; and
(7) Case Management (as an integral component of services 1-6 above).

(b) Medically necessary behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified behavioral health disorder(s). ~~A minimum of a 45 to 50 minute~~A one-on-one standard clinical session must be completed by ~~an~~a health care professional authorized in the approved FQHC State Plan pages in order to bill the PPS encounter rate for the session. Services rendered by providers not authorized under the approved FQHC state plan pages to bill the PPS encounter rate will be reimbursed pursuant to the SoonerCare fee-for-service fee schedule and must comply with

rules found at OAC 317:30-5-280 through 317:30-5-283. Behavioral health services must be billed on an appropriate claim form using appropriate Current Procedural Terminology (CPT) procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.
(c) Centers are reimbursed the PPS rate for services when rendered by approved health care professionals, as authorized under FQHC state plan pages, if the Health Center receives funding pursuant to Section 330 or is otherwise funded under Public Law to provide primary health care services at locations off-site (not including satellite or mobile locations) to Health Center patients on a temporary or intermittent basis, unless otherwise limited by Federal law.
(d) Health Centers that operate day treatment programs in school settings must meet the requirements found at OAC 317:30-5-240.2(b)(7).
(e) In order to support the member's access to behavioral health services, these services may take place in settings away from the Health Center. Off-site behavioral health services must take place in a confidential setting.

317:30-5-664.1. Provision of other health services outside of the Health Center core services
(a) If the Center chooses to provide other SoonerCare State Plan covered health services which are not included in the Health Center core service definition in OAC 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment and billing procedures described by the OHCA, and these services (e.g., home health services) are not included in the PPS settlement methodology in OAC 317:30-5-664.12.
(b) Other health services include, but are not limited to:
(1) dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;
(2) eyeglasses~~ (refer to OAC 317:30-5-450);~~ (OAC 317:30-5-430 and OAC 317:30-5-450);
(3) clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);
(4) technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);
(5) durable medical equipment (refer to OAC 317:30-5-210);
(6) emergency ambulance transportation (refer to OAC 317:30-5-335);
(7) prescribed drugs (refer to OAC 317:30-5-70);
(8) 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;
(9) specialized laboratory services furnished away from the clinic;
(10) Psychosocial Rehabilitation Services ~~[refer to OAC 317:30-5-241(a)(7)]~~[refer to OAC 317:30-5-241.3]; and
(11) behavioral health related case management services ~~(refer to OAC 317:30-5-240 through 317:30-5-249).~~(refer to OAC 317:30-5-241.6).

PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN INDIAN CLINICS (I/T/Us)

317:30-5-1087. Terms and definitions

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

(1) **"American Indian/Alaska Native (AI/AN)"** means an individual of Native American descent who has or is eligible for a Certificate of Degree of Indian Blood (CDIB) card.
(2) **"Behavioral Health services"** means professional medical services for the treatment of a mental health and/or ~~addiction disorder(s).~~substance use disorder.
(3) **"CFR"** means the Code of Federal Regulations.
(4) **"CMS"** means the Centers for Medicare and Medicaid Services.
(5) **"Encounter"** means a face to face contact between a health care professional and an IHS eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a 24-hour period ending at midnight, as documented in the patient's record.
(6) **"Licensed Behavioral Health Professional (LBHP)"** means a licensed psychologist, licensed clinical social worker(LCSW), licensed marital and family therapist (LMFT), licensed professional counselor (LPC), licensed behavioral practitioner (LBP) or licensed alcohol and drug counselor (LADC).
(7) **"OHCA"** means the Oklahoma Health Care Authority.
(8) **"OMB rate"** means the Medicaid reimbursement rate negotiated between CMS and IHS. Inpatient and outpatient Medicaid reimbursement rates for ~~I/T/US~~I/T/Us are published annually in the Federal Register or Federal Register Notices. The outpatient rate is also known as the I/T/U encounter rate. The encounter rate is available only to I/T/U facilities that appear on the IHS maintained listing of IHS-operated and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list.

(9) **"Physician"** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery or who is a licensed physician employed by the Federal Government in an IHS facility or who provides services in a 638 Tribal Facility.
(10) **"State Administering Agency (SAA)"** is the Oklahoma Health Care Authority.
(11) **"638 Tribal Facility"** is a facility that is operated by a tribe or tribal organization and funded by Title I or Title III of the Indian Self Determination and Education Assistance Act (Public Law 93-638).

317:30-5-1090. Provision of other health services outside of the I/T/U encounter

(a) Medically necessary SoonerCare covered services that are not included in the I/T/U outpatient encounter rate may be billed outside the encounter rate within the scope of the SoonerCare fee-for-service contract. The services will be reimbursed at the fee-for-service rate, and will be subject to any limitations, restrictions or prior authorization requirements. Examples of these services include but are not limited to:

~~(1) pharmaceuticals/drugs;~~
~~(2)~~(1) durable medical equipment;
~~(3)~~(2) glasses;
~~(4)~~(3) ambulance;
~~(5)~~(4) home health~~;~~ [refer to OAC 317:30-5-546];
~~(6)~~(5) inpatient practitioner services;
~~(7)~~(6) non-emergency transportation [refer to OAC 317:35-3-2];
~~(8)~~(7) behavioral health case management~~ [refer to OAC 317:30-5-240 through 317:30-5-249];~~ [refer to OAC 317:30-5-241.6];
~~(9)~~(8) psychosocial rehabilitative services~~ [refer to OAC 317:30-5-240 through 317:30-5-249];~~ [refer to OAC 317:30-5-241.3]; and
~~(10)~~(9) psychiatric residential treatment facility services ~~[refer to OAC 317:30-5-96.3].~~[refer to OAC 317:30-5, Part 6, Inpatient Psychiatric Hospitals].

(b) If the I/T/U facility chooses to provide other SoonerCare State Plan covered health services which are not included in the I/T/U encounter definition, those service providers must be contracted with OHCA and bill for those services under their assigned provider number consistent with program coverage limitations and billing procedures described by the OHCA.

317:30-5-1094. Behavioral health services provided at ~~I/T/US~~I/T/Us

(a) Behavioral health services that are primary, preventive, and therapeutic and would be covered if provided in another setting

may be provided by I/T/U providers. Services provided by an I/T/U (refer to OAC 317:30-5-241 for a description of services) must meet the same requirements as services provided by another provider. Services include:

(1) Mental Health and/or Substance Use Assessment/Evaluation and Testing;
(2) ~~Alcohol and/or Substance Abuse Services Assessment and Treatment~~Service Plan Development;
(3) Crisis Intervention Services;
(4) Medication Training and Support;
(5) Individual/~~interactive~~Interactive Psychotherapy;
(6) Group Psychotherapy; and
(7) Family Psychotherapy.

(b) Behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified mental health and/or substance ~~abuse~~use disorder(s).~~ A minimum of a 45 to 50 minute standard clinical session must be completed by an I/T/U in order to bill an encounter for the session. Treatment must be documented in accordance with OAC 317:30-5-248.~~ Behavioral health services must be billed on an appropriate claim form using appropriate Current Procedural Terminology (CPT) procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.

(c) In order to support access to mental health services, these services may be provided in settings outside of the I/T/U. Offsite services must take place in a confidential setting.

(d) The outpatient behavioral health services' provider enrollment and reimbursement process in no way changes the OHCA's policy with regard to reimbursement of practitioners. Licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and licensure candidates are not eligible for direct reimbursement as practitioners. Their services are compensable only when billed by their employers and when provided in those clinical settings in which they are currently approved to render services. Licensure candidates must meet the requirements contained in OAC 317:30-5-240.3.

(e) For the provision of behavioral health related case management services, I/T/U providers must meet the requirements found at OAC ~~317:30-5-240 through 317:30-5-249,~~317:30-5-241.6, and be contracted as such. The provision of these services is considered to be outside of the I/T/U encounter. Contracted behavioral health case management providers are responsible for obtaining all necessary prior authorizations, if needed, and will be paid at the current fee-for-service rate.

(f) For the provision of psychosocial rehabilitation services, I/T/U facilities meet the requirements found at OAC ~~317:30-5-240~~

~~through 317:30-5-249,~~317:30-5-241.3, and must contract as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter. Contracted psychosocial rehabilitation service providers are responsible for obtaining all necessary prior authorizations, if needed, and will be paid at the current fee-for-service rate.

317:30-5-1098. I/T/U outpatient encounters

(a) I/T/U outpatient encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by the OHCA. These services include health services included in the State Plan under Title XIX or Title XXI of the Social Security Act.

~~(b) The following words and terms have the following meaning unless the context clearly indicates otherwise:~~

(1) An I/T/U encounter means a face to face or ~~telemedicine~~telehealth contact between a health care professional and an IHS eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a 24-hour period ending at midnight, as documented in the patient's record.

(2) An I/T/U outpatient encounter means outpatient services that may be covered when furnished to a patient by a contracted SoonerCare provider employed by the I/T/U facility and rendered at the I/T/U facility or other location, including the patient's place of residence.

~~(c)~~(b) The following services may be considered reimbursable encounters subject to the limitations of the Oklahoma State Plan and include any related medical supplies provided during the course of the encounter:

(1) Medical;
(2) Diagnostic;
(3) Behavioral Health services [refer to OAC 317:30-5-1094];
(4) Dental, Medical and Mental Health Screenings;
(5) Vision;
(6) Physical Therapy;
(7) Occupational Therapy;
(8) Podiatry;
(9) Speech;
(10) Hearing;
(11) Visiting Nurse Service [refer to OAC 317:30-5-1093];
(12) Smoking and Tobacco Use Cessation Counseling;
(13) Other Title XIX or XXI services as allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules;
(14) Drugs or medication treatments provided during a clinic visit are part of the encounter rate. For example, a member has come into the clinic with high blood pressure and is treated at the clinic with a hypertensive drug or drug

sample. Drug samples are included in the encounter rate. ~~Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;~~ Prescription drugs are reimbursed pursuant to OAC 317:30-5-78(b)(4)(B).

(15) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members; and

(16) I/T/U Multiple Outpatient Encounters.

(A) OHCA will cover one medically necessary outpatient medical encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit with a different diagnosis. Then, a second encounter is allowed.

(B) OHCA will cover one dental encounter per member per day regardless of how many procedures are done or how many providers are seen unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(C) OHCA will cover one behavioral health professional outpatient encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(D) Each service must have distinctly different diagnoses in order to meet the criteria for multiple I/T/U outpatient encounters.

~~(d)~~(c) More than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. This does not imply that if a member is seen at a single office visit with multiple problems that multiple encounters can be billed. For example, a member comes to the clinic in the morning for an immunization, and in the afternoon, the member falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two encounters. However, a member who comes to the I/T/U facility for a diabetic wellness screening and is then referred to a podiatrist within the clinic for diabetes-related follow-up on the same date of service would not be considered a distinctly different diagnosis and can only be billed as a single encounter.

~~(e)~~(d) The following services may be considered as separate or multiple encounters when two or more services are provided on the same date of service with distinctly different diagnoses:

(1) Medical Services;

(2) Dental Services

(3) Mental Health and addiction services with similar

diagnoses can only be billed as one encounter. In addition, if the member is also seen for a medical office visit with a mental health or addiction diagnosis, then it is considered a single encounter;

(4) Physical or occupational therapy (PT/OT). If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter;

(5) Administration of immunizations. If no other medical office visit occurs on the same date of services; and

(6) Tobacco cessation limited to state plan services. If no other medical or addiction encounter occurs on the same date of service.

~~(f)~~(e) I/T/U outpatient encounters for IHS eligible SoonerCare members whether medical, dental, or behavioral health, are not subject to prior authorization. Other State Plan covered services that the I/T/U facility chooses to provide but which are not part of the I/T/U encounter are subject to all applicable SoonerCare regulations which govern the provision and coverage for that service.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
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SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-20. Laboratory services

This Section covers the guidelines for payment of laboratory services by a provider in his/her office, a certified laboratory and for a pathologist's interpretation of laboratory procedures.

(1) **Compensable services.** Providers may be reimbursed for compensable clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a provider refers specimen to a certified laboratory or a hospital laboratory serving outpatients, the certified laboratory or the hospital must bill for performing the test.

(A) Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from CMS and have a current contract on file with the OHCA.

(B) Only medically necessary laboratory services are compensable.

(2) **Non-compensable laboratory services.**

(A) Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected by a laboratory. These services are considered part of the laboratory analysis.

(B) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital rate.

(C) Billing multiple units of nucleic acid detection for individual infectious organisms when testing for more than one infectious organism in a specimen is not permissible. Instead, OHCA considers it appropriate to bill a single unit of a procedure code indicated for multiple organism testing.

~~(D) Laboratory services must be medically indicated to be compensable.~~

(D) Billing multiple Current Procedural Terminology (CPT) codes or units for molecular pathology tests that examine multiple genes or incorporate multiple types of genetic analysis in a single run or report is not permissible. Instead, OHCA considers it appropriate to bill a single

CPT code for such test. If an appropriate code does not exist, then one unit for an unlisted molecular pathology procedure may be billed.

(3) **Covered services by a pathologist.**

(A) A pathologist may be paid for the interpretation of inpatient surgical pathology specimen when the appropriate CPT procedure code and modifier is used.

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or Ambulatory Surgery Center setting.

(4) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:

(A) Experimental or investigational procedures.

(B) Interpretation of clinical laboratory procedures.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.16. Related services

(a) **Ambulance.** Ambulance services furnished by the facility are covered separately if otherwise compensable under the Authority's Medical Programs.

(b) **Home health care.** Hospital based home health providers must be Medicare certified and have a current Home Health Agency contract with the OHCA. For home health services, a qualified provider must conduct and document a face-to-face encounter with the member in accordance with provisions of 42 CFR 440.70.

(1) Payment is made for home health services provided in a member's residence to all categorically needy individuals.

(2) Payment is made for a maximum of 36 visits per year for eligible members 21 years of age or older. Payment for any combination of skilled and home health aide visits can not exceed 36 visits per year.

(3) Payment is made for standard medical supplies.

(4) Payment is made on a rental or purchase basis for equipment and appliances suitable for use in the home.

(5) Non-covered items include sales tax, enteral therapy and nutritional supplies, and electro-spinal orthosis systems (ESO).

(6) Payment may be made to home health agencies for prosthetic devices.

(A) Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is considered most appropriate.

(B) Payment is made for permanent indwelling catheters, drain bags, insert trays and irrigation trays. Male external catheters are also covered.

(C) Sterile tracheotomy trays are covered.

(D)~~Payment~~ Payment is made for colostomy and urostomy bags and accessories.

(E) Payment is made for hyperalimentation, including supplements, supplies and equipment rental on behalf of persons having permanently inoperative internal body organ dysfunction. Information regarding the member's medical condition that necessitates the hyperalimentation and the expected length of treatment, should be attached when requesting prior authorization.

(F) Payment is made for ventilator equipment and supplies when prior authorized.

(G) Payment for medical supplies, oxygen, and equipment is

made when using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.

(c) **Hospice Services.** Hospice is defined as palliative and/or comfort care provided to the member family when a physician certifies that the member has a terminal illness and has a life expectancy of six months or less. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

(1) Payment is made for home based hospice services for terminally ill individuals under the age of 21 with a life expectancy of six months or less when the member and/or family has elected hospice benefits. Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family.

(2) Hospice care is available for two initial 90-day periods and an unlimited number of subsequent 60-day periods during the remainder of the member's lifetime. Beginning January 1, 2011, a hospice physician or nurse practitioner must have a face to face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter; and attests that such visit took place. The member and/or the family may voluntarily terminate hospice services.

(3) Hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the member is terminally ill must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify the terminal illness; however, effective January 1, 2011, nurse practitioners may re-certify the terminal illness.

(4) Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

PART 61. HOME HEALTH AGENCIES

317:30-5-546. Coverage by category

Payment is made for home health services as set forth in this ~~Section.~~section when a face to face encounter has occurred in accordance with provisions of 42 CFR 440.70.

(1) **Adults.** Payment is made for home health services provided in the ~~patient's~~member's residence to all categorically needy individuals. Coverage for adults is as follows.

(A) **Covered items.**

(i) Part-time or intermittent nursing services;

(ii) Home health aide services;

(iii) Standard medical supplies;

(iv) Durable medical equipment (DME) and appliances; and

(v) Items classified as prosthetic devices.

(B) **Non-covered items.** The following are not covered:

(i) Sales tax;

(ii) Enteral therapy and nutritional supplies;

(iii) Electro-spinal orthosis system (ESO); and

(iv) Physical therapy, occupational therapy, speech pathology, or audiological services.

(2) **Children.** Home Health Services are covered for persons under age 21.

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