**Rules Agenda**
September 13, 2007

**Items subject to the Administrative Procedures Act (Emergency)**

Page 2 A. Revising rules to postpone until 2011 the requirement that suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) must be accredited by a Medicare-deemed accreditation organization for quality standards for DMEPOS suppliers in order to receive reimbursement from the SoonerCare program. **(APA WF # 07-48)**

Page 4 B. Revising SoonerCare application procedure rules to allow the acceptance of facsimile signatures on all SoonerCare applications. **(APA WF # 07-25)**

Page 8 C. Revising rules to add Licensed Genetic Counselors (LGCs) to individual providers and specialties who provide health care to SoonerCare members. **(APA WF # 07-41)**

Page 11 D. Revising rules to add Registered Lactation Consultants (RLCs) and International Board Certified Lactation Consultants (IBCLCs) to individual providers and specialties who provide health care to SoonerCare members. **(APA WF # 07-42)**

Page 14 E. Revising rules to add Maternal and Infant Health Licensed Clinical Social Workers (MIHLCSWs) to individual providers and specialties who provide health care to SoonerCare members. **(APA WF # 07-40)**

Page 18 F. Revising rules to permit additional reimbursement to providers treating a member who is confirmed to be medically/obstetrically "high risk" and allow additional ultrasounds and non stress tests needed beyond the basic benefit. **(APA WF # 07-38)**

I. **Items subject to the Administrative Procedures Act (Emergency).**

A. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 17. Medical Suppliers
OAC 317:30-5-210. [AMENDED]
**(Reference APA WF # 07-48)**

**FINDING OF EMERGENCY:** The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to allow SoonerCare contracted providers of durable medical equipment, prosthetics, orthotics and supplies an obtainable deadline for attaining accreditation by a Medicare deemed accreditation organization. The deadline of January 1, 2008, previously set by the agency will not be met by many current SoonerCare providers due to the inability of the accreditation organizations to complete the lengthly, cumbersome process by the end of the year deadline for the number of providers who currently have requested accreditation. If the accreditation requirement is not postponed, SoonerCare members may experience difficulty in obtaining needed services.

**SUMMARY:** Agency rules are revised to delay the SoonerCare requirement of accreditation by a Medicare deemed accreditation organization for quality standards for providers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). In May, 2007, the agency revised rules effective July 1, 2007, to require this accreditation by January 1, 2008; however, it has now been determined that the accreditation organizations will be unable to complete the accreditation process for current SoonerCare contracted providers for two more years. Therefore, the deadline for DMEPOS providers to obtain this accreditation in order to receive reimbursement from SoonerCare is being delayed until January 1, 2011.

**BUDGET IMPACT:** Agency staff has determined that the revisions are budget neutral to the agency.

**RULE LENGTH IMPACT:** These revisions will have no significant impact on the length of agency rules.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on February 10, 2007, and recommended Board approval.

**PROPOSED EFFECTIVE DATE:** November 1, 2007, or immediately upon Governor's approval, whichever is later.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 424.57(c)

**RESOLUTION:**
**Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:**
Revising rules to postpone until 2011 the requirement that suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) must be accredited by a Medicare-deemed accreditation organization for quality standards for DMEPOS suppliers in order to receive reimbursement from the SoonerCare program.

## CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
## PART 17. MEDICAL SUPPLIERS

### 317:30-5-210. Eligible providers

All eligible medical suppliers must have a current contract with the Oklahoma Health Care Authority. The supplier must comply with all applicable State and Federal laws. Effective January 1, ~~2008~~ 2011, all suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) must be accredited by a Medicare deemed accreditation organization for quality standards for DMEPOS suppliers in order to bill the SoonerCare program. OHCA may make exceptions to this standard if it is determined that a supplier may provide acceptable service to an under served location.

B. **CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**
Subchapter 6. SoonerCare Health Benefits for Categorically Needy Pregnant Women and Families with Children
Part 3. Application Procedures
OAC 317:35-6-15. [AMENDED]
Subchapter 7. Medical Services
Part 3. Application Procedures
OAC 317:35-7-15. [AMENDED]
**(Reference APA WF # 07-25)**

**FINDING OF EMERGENCY:** The Agency finds that imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions that allow the acceptance of facsimile signatures on all SoonerCare applications. Without these revisions, SoonerCare members could experience a delay in accessing needed medical attention.

**SUMMARY:** Application procedure rules for medical assistance are revised to allow the acceptance of facsimile signatures on all SoonerCare applications and would not require an original signature to follow. There is no current rule in policy which speaks to obtaining original signatures on SoonerCare applications; however, current practices require caseworkers to obtain original signatures on applications. Not allowing facsimile signatures may delay the processing of SoonerCare applications, impeding members from accessing needed medical attention.

**BUDGET IMPACT:** Agency staff have determined that these revisions are budget neutral.

**RULE LENGTH IMPACT:** These revisions have no significant impact on the length of agency rules.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on July 19, 2007, and recommended Board approval.

**PROPOSED EFFECTIVE DATE:** November 1, 2007, or immediately upon Governor's approval, whichever is later.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 435.907

**RESOLUTION:**

**Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:**

Revising SoonerCare application procedure rules to allow the acceptance of facsimile signatures on all SoonerCare applications.

**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**
**PART 6. INPATIENT PSYCHIATRIC HOSPITALS**

**317:35-6-15. Application for SoonerCare Health Benefits for Pregnant Women and Families with Children; forms**

(a) **Application**. An application for categorically needy pregnant women and families with children consists of the Health Benefits Application. The application form is signed by the individual, parent, spouse, guardian, or someone else acting on the individual's behalf. A categorically needy individual does not have to have received a medical service nor expect to receive one to be certified for Health Benefits for Pregnant Women and Families with Children.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility, Health Department, or in the county ~~DHS~~ OKDHS office. A face to face interview is not required. Applications may be mailed or faxed to the local county ~~DHS~~ OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for ~~Health Benefits~~ health benefits, the physician or facility may forward an application to the ~~DHS~~ OKDHS county office of the patient's residence for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application.

(2) Form ~~MS-MA-5~~ 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the Health Benefits Application form or Form ~~MS-MA-5~~ 08MA005E constitutes an application for ~~Medicaid~~ SoonerCare.

(4) If Form ~~MS-MA-5~~ 08MA005E is received and an application cannot be completed, receipt of Form ~~MS-MA-5~~ 08MA005E constitutes an application which must be registered and subsequently denied. The ~~client~~ member and provider are

notified by computer-generated notice.

(b) **Date of application**. When application is made in the county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application or Form ~~MS-MA-5~~ 08MA005E is stamped into the county office. When an application is faxed, the application date is the date the fax is received. When a request for Health Benefits is first made by an oral request to the county office, and the application form is signed later, the date of the oral request is entered in "red" on the application form above the date the form is signed. The date of the oral request is the date of application to be shown on the computer form. When Form ~~MS-MA-5~~ 08MA005E is received in the county office prior to the completion of the application form, the date that Form ~~MS-MA-5~~ 08MA005E is received is considered as the date of application and must be registered as an application. Certain providers may take applications and then forward them to the ~~DHS~~ OKDHS county office for Health Benefits eligibility determination. Under this circumstance, the application date is the date the ~~client~~ member signed the application form for the provider.

**SUBCHAPTER 7. MEDICAL SERVICES**
**PART 3. APPLICATION PROCEDURES**

**317:35-7-15. Application for Medical Services; forms**

(a) **Application**. An application for Medical Services consists of the Medical Assistance Application. The application form is signed by the individual, parent, spouse, guardian or someone else acting on the individual's behalf. A categorically needy individual does not have to have received a medical service nor expect to receive one to be certified for ~~Medicaid~~ SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility or in the county ~~DHS~~ OKDHS office. A face to face interview is not required. Applications may be mailed or faxed to the local county OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for ~~Medicaid~~ health benefits, the physician or facility may forward an application or ~~MS-MA-5~~ 08MA005E to the ~~DHS~~ OKDHS county office of the patient's residence for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application.

(2) Form ~~MS-MA-5~~ 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical

service. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the Medical Assistance Application form or Form ~~MS-MA-5~~ 08MA005E constitutes an application for ~~Medicaid~~ SoonerCare.

(4) If Form ~~MS-MA-5~~ 08MA005E is received and an application cannot be completed, receipt of Form ~~MS-MA-5~~ 08MA005E constitutes an application which must be registered and subsequently denied. The ~~client~~ member and provider are notified by computer-generated notice.

(5) If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the Medical Assistance Application form.

(b) **Date of application**. When application is made in the county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application or Form ~~MS-MA-5~~ 08MA005E is stamped into the county office. When an application is faxed, the application date is the date the fax is received. When a request for ~~Medicaid~~ SoonerCare is first made by an oral request to the county office, and the application form is signed later, the date of the oral request is entered in "red" on the application form above the date the form is signed. The date of the oral request is the date of application to be shown on the computer form. When Form ~~MS-MA-5~~ 08MA005E is received in the county office prior to the completion of the application form, the date that Form ~~MS-MA-5~~ 08MA005E is received is considered as the date of application and must be registered as an application. Certain providers may take applications and then forward them to the ~~DHS~~ OKDHS county office for ~~Medicaid~~ SoonerCare eligibility determination. Under this circumstance, the application date is the date the ~~client~~ member signed the application form for the provider.

C. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 18. Genetic Counselors
OAC 317:30-5-219. through 317:30-5-223. [NEW]
**(Reference APA WF # 07-41)**

**FINDING OF EMERGENCY:** The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions that add Licensed Genetic Counselors (LGCs) to individual providers and specialties who provide health care to SoonerCare members. The field of genetics has developed tests and procedures that have significant impact on perinatal care. Genetic counselors interpret complex test results, analyze inheritance patterns and reoccurrence risk, as well as provide supportive counseling. The addition of LGCs will increase access to genetic counseling services for pregnant/postpartum SoonerCare members and allow women/couples, who have been told their pregnancy is at an increased risk for a birth defect or genetic condition, to choose a course of action appropriate for them in view of their risk, their family goals, and their ethical and religious standards. If revisions are not made, SoonerCare members will not have the benefit of these services which are vital to the understanding of congenital birth defects.

**SUMMARY:** Rules are revised to add Licensed Genetic Counselors (LGCs) to individual providers and specialties who provide health care to SoonerCare members. The field of genetics has developed tests and procedures that have significant impact on perinatal care. Genetic counseling is a process by which critical family history, patient history, and other factors are gathered, analyzed and shared with the member in order to help them understand and adapt to the medical psychosocial and familial contributions to potential or realized birth defects. Proposed rule revisions are a result of the Oklahoma State Department of Health and Oklahoma Health Care Authority Perinatal Task Force. The focus of this task force is to study issues concerning pregnant women covered by SoonerCare and other public funding sources and to develop programs and plans to target those areas for positive outcomes. This revision to rules will allow Genetic Counselors to contract directly with the OHCA and expand the number of providers allowed to provide services to SoonerCare members.

**BUDGET IMPACT:** Agency staff have estimated that this

expansion will cost $42,390 for state fiscal year 2008 with a state share of $13,836.

**RULE LENGTH IMPACT:** These revisions have no significant impact on the length of agency rules.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on July 19, 2007, and recommended Board approval.

**PROPOSED EFFECTIVE DATE:** December 1, 2007, or immediately upon Governor's approval, whichever is later.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; CFR 440.250(p)

**RESOLUTION:**
**Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:**
Revising rules to add Licensed Genetic Counselors (LGCs) to individual providers and specialties who provide health care to SoonerCare members.

## CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
## PART 18. GENETIC COUNSELORS

### 317:30-5-219. General Information

Genetic counseling gathers critical family history, patient history, and other factors to be analyzed and shared with the member to help them understand and adapt to the medical, psychosocial and familial contributions to potential or realized birth defects.

### 317:30-5-220. Eligible Providers

Eligible providers must be Licensed Genetic Counselors. Genetic Counselors must have a current contract on file with the Oklahoma Health Care Authority and be licensed in the state in which the service is being provided.

### 317:30-5-221. Coverage

(a) Services for pregnant/postpartum SoonerCare members must be referred by a provider involved in the provision of obstetric or pediatric care. Members are eligible for genetic counseling during pregnancy which includes 60 days postpartum. Reasons for genetic

counseling include but are not limited to the following:

(1) advanced maternal age;
(2) abnormal maternal serum first or second screening;
(3) previous child or current fetus/infant with an abnormality;
(4) consanguinity/incest;
(5) parent is a known carrier or has a family history of a genetic condition;
(6) parent was exposed to a known or suspected reproductive hazard;
(7) previous fetal demise, stillbirth, or neonatal death involving known/suspected abnormalities;
(8) history of recurrent pregnancy loss; or
(9) parent(s) are in an ethnic or racial group associated with an increased risk for specific genetic conditions.

(b) These services may be provided in an office or outpatient setting.

**317:30-5-222. Reimbursement**

(a) Counseling services must be billed using appropriate CPT codes and guidelines and must be medically necessary. SoonerCare does not allow more than six units (30 minutes = 1 unit) per pregnancy including 60 days postpartum care.

(b) Genetic Counselors who are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

**317:30-5-223. Documentation**

All services must be documented in the member's medical record. All prenatal and postpartum genetic counseling sessions must at a minimum include the following:

(1) date of service;
(2) start and stop time for each treatment session;
(3) practitioner's signature;
(4) pedigree, and/or review and interpretation of family history; and
(5) recommendation and plan of care.

D. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 20. Lactation Consultants
OAC 317:30-5-230. through 317:30-5-234. [NEW]
**(Reference APA WF # 07-42)**

**FINDING OF EMERGENCY:** The Agency finds that imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions that add Registered Lactation Consultants (RLCs) and International Board Certified Lactation Consultants (IBCLCs) to individual providers and specialties who provide health care to SoonerCare members. Research has confirmed the importance of breastfeeding and breast milk for the optimal health of infants, children and mothers. The addition of RLCs and IBCLCs will increase access to lactation services for pregnant/postpartum SoonerCare members and increase the number of SoonerCare members who breastfeed. Without these revisions, the SoonerCare program will be unable to impact the number of SoonerCare members who elect to breastfeed.

**SUMMARY:** Rules are revised to add Registered Lactation Consultants (RLCs) and International Board Certified Lactation Consultants (IBCLCs) to individual providers and specialties who provide health care to SoonerCare members. Research has confirmed the importance of breastfeeding and breast milk for the optimal health of infants, children and mothers. Professional lactation services provide counseling or behavioral interventions to improve breastfeeding outcomes. Currently, access to lactation education and counseling is limited for SoonerCare members. Proposed rule revisions are a result of the Oklahoma State Department of Health and the Oklahoma Health Care Authority Perinatal Task Force. The focus of this task force is to study issues concerning pregnant women covered by SoonerCare and other public funding sources and to develop programs and plans to target those areas for positive outcomes. This revision to rules will allow Lactation Consultants to contract directly with the OHCA and will increase access to lactation services for pregnant/postpartum SoonerCare members.

**BUDGET IMPACT:** Agency staff have estimated that this expansion will cost $278,656 annually with a state share of $90,953.

**RULE LENGTH IMPACT:** These revisions have no significant

impact on the length of agency rules.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on July 19, 2007, and recommended Board approval.

**PROPOSED EFFECTIVE DATE:** December 1, 2007, or immediately upon Governor's approval, whichever is later.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; CFR 440.250(p).

**RESOLUTION:**
**Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:**
Revising rules to add Registered Lactation Consultants (RLCs) and International Board Certified Lactation Consultants (IBCLCs) to individual providers and specialties who provide health care to SoonerCare members.

**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**
**PART 20. LACTATION CONSULTANTS**

**317:30-5-230. General Information**

Lactation Consultant services provide counseling and/or behavioral interventions to improve breastfeeding outcomes. The primary focus of this service is member-specific support and education regarding breastfeeding, addressing particular issues, and/or managing lactation crisis.

**317:30-5-231. Eligible Providers**

Eligible providers are International Board Certified Lactation Consultants (IBCLCs) or Registered Lactation Consultants (RLCs). IBCLCs and RLCs must have a current contract on file with the Oklahoma Health Care Authority.

**317:30-5-232. Coverage**

Lactation Consultant services are covered for pregnant women and women up to 60 days postpartum. SoonerCare members may self-refer or be referred by any provider. Reasons for lactation services include but are not limited to the following:

(1) prenatal education/training for first time mothers;

(2) women who have not previously breastfed, have a history of breastfeeding difficulty, have identified risk factors for

breastfeeding difficulty or lactation insufficiency (e.g., history of breast surgery, infertility, hormonal imbalance, diabetes, obesity);
(3) women expecting an infant with risk factors for ineffective breastfeeding (e.g., preterm, multiples, congenital birth defects);
(4) latch-on difficulties;
(5) low milk supply;
(6) breastfeeding a premature baby (36 weeks or less gestation);
(7) breastfeeding multiples; and
(8) a baby with special needs (e.g., Down Syndrome, cleft lip/or palate).

**317:30-5-233. Limitations**

(a) Services billed by a contracted IBCLC/RLC are only covered when performed in the IBCLC's/RLC's office setting, patient's home, or other confidential outpatient setting. Payment for inpatient services provided by a Lactation Consultant is included in the hospital's per diem rate.
(b) No separate reimbursement will be made to a facility.
(c) Services are not to duplicate any basic breastfeeding education/training a member may have received through another program such as WIC or the Children's First Program and services must be problem focused.
(d) Services provided by a contracted IBCLC/RLC must be provided face-to-face and in an individual setting.

**317:30-5-234. Reimbursement**

(a) IBCLCs/RLCs who are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.
(b) Reimbursement is limited to not more than 6 sessions per pregnancy and must be objectively documented as medically necessary.

**317:30-5-235. Documentation**

All services must be documented in the member's medical record. All prenatal and postpartum lactation sessions must, at a minimum, include the following:
(1) date of service;
(2) start and stop time for each session;
(3) practitioner's signature; and
(4) recommendation and plan of care.

E. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 16. Maternal and Infant Health Licensed Clinical Social Workers
OAC 317:30-5-204. through 317:30-5-209. [NEW]
**(Reference APA WF # 07-40)**

**FINDING OF EMERGENCY:** The Agency finds that imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions that add Maternal and Infant Health Licensed Clinical Social Workers (MIHLCSWs) to individual providers and specialties who provide health care to SoonerCare members. Services provided by MIHLCSWs consist of supportive counseling, education, and case management toward the goal of reducing poor perinatal outcomes. The addition of MIHLCSWs will increase access to counseling services for pregnant/postpartum SoonerCare members who may be at risk due to drug/alcohol use, domestic violence, and/or problems in the post partum environment that interfere with infant health and bonding. If revisions are not made, SoonerCare members will not have the benefit of these services which are vital to improving perinatal outcomes and optimizing early maternal infant health.

**SUMMARY:** Rules are revised to add Maternal and Infant Health Licensed Clinical Social Workers (MIHLCSWs) to individual providers and specialties who provide health care to SoonerCare members. Services provided by MIHLCSWs consist of supportive counseling, education, and case management toward the goal of reducing poor perinatal outcomes and optimizing early maternal infant health, attachment and bonding. The emphasis is on providing support, motivation, education and assistance in accessing appropriate care. The addition of MIHLCSWs will increase access to counseling services for pregnant/postpartum SoonerCare members who may be at risk due to drug/alcohol use, domestic violence, and/or problems in the post partum environment that interfere with infant health and bonding. Proposed rule revisions are a result of the Oklahoma State Department of Health and the Oklahoma Health Care Authority Perinatal Task Force. The focus of this task force is to study issues concerning pregnant women covered by SoonerCare and other public funding sources and to develop programs and plans to target those areas for positive outcomes. This revision will allow MIHLCSWs to contract directly with the OHCA and expand the number of providers allowed to provide services to SoonerCare members.

**BUDGET IMPACT:** Agency staff have estimated that this expansion will cost $488,141 annually with a state share of $159,329.

**RULE LENGTH IMPACT:** These revisions have no significant impact on the length of agency rules.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on July 19, 2007, and recommended Board approval.

**PROPOSED EFFECTIVE DATE:** December 1, 2007, or immediately upon Governor's approval, whichever is later.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; CFR 440.250(p)

**RESOLUTION:**
**Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:**
Revising rules to add Maternal and Infant Health Licensed Clinical Social Workers (MIHLCSWs) to individual providers and specialties who provide health care to SoonerCare members.

**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**
**PART 16. MATERNAL AND INFANT HEALTH LICENSED CLINICAL SOCIAL WORKERS**

**317:30-5-204. General Information**

Maternal and infant health licensed clinical social work services consist of supportive counseling and education toward the goal of reducing poor perinatal outcomes and optimizing early maternal infant health, attachment and bonding. The emphasis is on providing psychosocial support, health and behavior assessment and intervention focused on biopsycho-social factors related to the member's perinatal health status. These services are intended for women who are at risk due to drug/alcohol use, domestic violence, lack of stable food/shelter, high risk medical conditions, problems in the post partum environment that interfere with the infant health and bonding, and/or other psychosocial concerns.

**317:30-5-205. Eligible Providers**

Eligible providers are Licensed Clinical Social Workers (LCSWs) with a minimum of six hours of continuing education or technical assistance in the area of Maternal and Infant Health. LCSWs must have a current contract on file with the Oklahoma Health Care Authority and be licensed in the state in which the service is being provided. Services may also be provided through the Department of Health or other county health departments. Services provided through the health departments must be provided by a LCSW. In the event of a post-payment audit, LCSWs providing Maternal and Infant Health Clinical Social Work services must be able to demonstrate that they have completed at least six hours of continuing education or technical assistance for each calendar year of providing care to SoonerCare members. The continuing education or technical assistance must be in the area of Maternal and Infant Health relevant to the provision of Social Work Services.

**317:30-5-206. Coverage**

Maternal and infant health social work services are covered for pregnant and postpartum women for whom a psychosocial condition exists that may negatively impact the pregnancy and/or well being of the newborn infant. SoonerCare members may self-refer or be referred by any provider. Identification of the condition may be based on a CH-16 or the Licensed Clinical Social Worker's initial assessment. Psychosocial assessment/counseling is appropriate in order to develop a social work care plan based upon the health risks due to psychosocial factors.

**317:30-5-207. Limitations**

Coverage limitations for maternal and infant health social work services are as follows:

(1) Services are only covered when performed in the LCSWs' office setting, patient's home or other confidential clinic setting.

(2) No separate reimbursement will be made to a facility.

(3) Services billed by a contracted LCSW must be provided face-to-face and in an individual setting.

**317:30-5-208. Reimbursement**

(a) Maternal and infant health social work services must be billed using appropriate CPT codes and guidelines.

(b) SoonerCare does not allow more than 32 units (15 minutes = 1 unit) during the pregnancy which includes 60 days postpartum.

(c) LCSWs who are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

(d) Only the LCSW directly performing the care or a county health department may bill the SoonerCare Program.

(e) The time indicated on the claim form must be the time actually

spent with the member.

**317:30-5-209. Documentation**

All services must be reflected by documentation in the patient records. All assessment and treatment services must include the following:

(1) date;
(2) start and stop time for each timed treatment session;
(3) signature of the service provider;
(4) credentials of service provider;
(5) documentation of the referral source;
(6) problems(s), goals and/or objectives identified on the treatment plan;
(7) methods used to address the problem(s), goals and objectives;
(8) progress made toward goals and objectives;
(9) patient response to the session or intervention; and
(10) any new problem(s), goals and/or objectives identified during the session.

F. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
OAC 317:30-5-22. [REVISED]
OAC 317:30-5-22.1. [NEW]
**(Reference APA WF # 07-38)**

**FINDING OF EMERGENCY:** The Agency finds that imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions that add enhanced services for medically high risk pregnancies and allow additional reimbursement to an obstetrical care provider treating a member who is confirmed to be medically/obstetrically "high risk". Enhanced services will be available for pregnant women eligible for SoonerCare and will be in addition to services for uncomplicated maternity cases. The additional reimbursement and services will increase access to Maternal and Fetal Medicine Specialists and ensure high risk pregnant SoonerCare members receive appropriate prenatal care and services. If revisions are not made, SoonerCare members will not have the necessary access to these specialists and services.

**SUMMARY:** Rules are revised to add enhanced services for medically high risk pregnancies and allow additional reimbursement to an obstetrical care provider treating a member who is confirmed to be medically/obstetrically “high risk”. 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 may receive prior authorization for medically necessary enhanced benefits which include prenatal at risk ante partum management, non stress test(s), and additional ultrasounds not covered under routine obstetrical care. Proposed rule revisions are a result of the Oklahoma State Department of Health and the Oklahoma Health Care Authority Perinatal Task Force. The focus of this task force is to study issues concerning pregnant women covered by SoonerCare and other public funding sources and to develop programs and plans to target those areas for positive outcomes. These rule revisions will ensure high risk pregnant SoonerCare members receive appropriate prenatal care in an effort to significantly reduce the possibility of poor birth outcomes.

**BUDGET IMPACT:** Agency staff have estimated that this

expansion will cost $1,109,651 annually with a state share of $362,190.

**RULE LENGTH IMPACT:** These revisions have no significant impact on the length of agency rules.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on July 19, 2007, and recommended Board approval.

**PROPOSED EFFECTIVE DATE:** December 1, 2007, or immediately upon Governor's approval, whichever is later.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; CFR 440.250(p)

**RESOLUTION:**
**Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:**
Revising rules to permit additional reimbursement to providers testing a member who is confirmed to be medically/obstetrically "high risk" and allow additional ultrasounds and non stress tests needed beyond the basic benefit.

## CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
## PART 1. PHYSICIANS

### 317:30-5-22. Obstetrical care

(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 ante partum visits. The ante partum 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) - (6) of this subsection.

(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form and the most recent version of the Oklahoma Health Care ~~Authority (OHCA),~~ 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 ante partum diagnostic ultrasounds will be paid for in addition to ante partum care, delivery and post partum obstetrical care under defined circumstances. To be eligible for payment, 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 certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a 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 certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification in Obstetrical ultrasonography.

(C) Additional ultrasounds, including detailed ultrasounds and re-evaluations of previously identified or suspected fetal or maternal anomalies, must be performed by an active candidate or Board Certified diplomat in Maternal-Fetal Medicine.

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

(4) Spinal anesthesia administered by the attending physician is a compensable service and is billed separately from the delivery.

(5) Amniocentesis is not included in routine obstetrical care and is billed separately.

(6) Additional payment is not made for the delivery of twins. If one twin is delivered vaginally and one is delivered by C-section by the same physician, the higher level procedure is paid. If one twin is delivered vaginally and one twin is 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.

(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 should bill separately for the prenatal and the six weeks postpartum office visit.

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

(1) ~~An additional allowance is not be made for induction of labor, double set-up examinations, fetal stress and non-stress tests, or pudendal anesthetic. Do not bill separately for these procedures.~~ Non-stress tests except as described in 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 assistant surgery for obstetrical procedures which include prenatal or post partum care.

(4) ~~Pitocin induction of labor is considered part of the delivery and separate payment is not made.~~ 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.

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

(e) Obstetrical coverage for children is the same as for adults with additional procedures being covered due to 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 may receive prior authorization for medically necessary enhanced benefits which include:

(1) prenatal at risk ante partum management;

(2) a combined maximum of 12 fetal non stress test(s)and

biochemical profiles; and

(3) a maximum of 6 repeat ultrasounds not covered under 30-5-22(b)(2).

(b) **Prior Authorization.** In order to receive enhanced services, the following documentation must be received by the OHCA Medical Authorizations Unit for review/approval:

(1) ACOG or other comparable comprehensive assessment;

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

(3) a treatment plan signed by the primary provider of obstetric care, a Maternal Fetal Medicine specialist who has agreed to provide collaborative care, and the SoonerCare member. The treatment plan must contain the following:

(A) a description of care to be provided by the Maternal Fetal Medicine specialist;

(B) a description of care to be provided by the primary provider of obstetrical care;

(C) anticipated number of non stress test(s) and biochemical profiles needed (if applicable); and

(D) anticipated number of follow-up ultrasounds needed.

(c) **Reimbursement.** Enhanced benefits will be reimbursed as follows:

(1) ante partum management for high risk will be reimbursed to the primary provider of obstetrical care.

(2) reimbursement for enhanced at risk ante partum management will not be available to physicians who already qualify for enhanced reimbursement as state employed physicians.

(3) reimbursement for enhanced at risk ante partum management will not be made during an in-patient hospital stay.