Rules Agenda
June 12, 2008

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

Page 2 A. Revising rural health clinic rules to: (1) eliminate age and gender restrictions for SoonerCare members to receive family planning services; and (2) reimburse on a fee-for-service rather than an encounter basis. **(Reference APA WF # 08-11)**

Page 5 B. Revising Physician rules to: (1) allow reimbursement of one non stress test and/or one biophysical profile to a Maternal Fetal Medicine (MFM) specialist without requiring a prior authorization; and (2) remove the OB signature requirement from the high risk OB treatment plan form unless the OB provider wishes to request authorization of the ante partum management fee. **(Reference APA WF # 08-12)**

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

A. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 35. Rural Health Clinic
OAC 317:30-5-356. [AMENDED]

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 remove the age and gender restrictions for persons eligible for family planning services. With these revisions, the only limitation for otherwise eligible SoonerCare members is reproductive capability. The less restrictive requirement will enable the SoonerCare program to serve a larger population of members through rural health clinics who are in need of family planning services which may result in a lower rate of unwanted pregnancies in Oklahoma.

SUMMARY: Rural Health Clinic rules are revised to eliminate the age and gender restrictions for SoonerCare members who are eligible to receive family planning services. The revision removes the reference to age and gender, with the only limitation for otherwise eligible SoonerCare members being reproductive capability. Potentially, fewer unwanted pregnancies may result by enlarging the population of individuals who are eligible to receive family planning services through rural health clinics. The revision also brings policy into current practice of payment based on fee-for-service rather than an encounter basis.

BUDGET IMPACT: Agency staff has determined that the revisions will have a minimal budget impact with additional expenditures of approximately $1000 per year; the state share will be approximately $329.

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 May 15, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: August 1, 2008, 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 441.20 and 440.250

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising rural health clinic rules to: (1) eliminate age and gender restrictions for SoonerCare members to receive family planning services; and (2) reimburse on a fee-for-service rather than an encounter basis.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 35. RURAL HEALTH CLINIC

317:30-5-356. Coverage for adults

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

(1) **RHC services.** Payment is limited to four visits per ~~recipient~~ member per month. Refer to OAC 317:30-1, General Provisions, and OAC ~~317:30-3-65.4~~ 317:30-3-65.2 for exceptions to this limit for children under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Additional preventive service exceptions include:

(A) **Obstetrical care.** A Rural Health Clinic should have a written contract with its physician, nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how ~~maternity~~ obstetrical care will be billed to ~~Medicaid~~ SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for rural health and non-rural health clinic (other ambulatory) services.

(i) If the clinic compensates the physician, nurse midwife or advanced practice nurse to provide ~~maternity~~ obstetrical care, then the clinic must bill the ~~Medicaid~~ SoonerCare program for ~~prenatal care as a "maternity encounter"~~ each prenatal visit using the appropriate CPT evaluation and management codes. ~~A maternity encounter includes a comprehensive physical examination and/or routine scheduled medical visits. Payment will be allowed for one initial visit and 13 subsequent visits:~~

~~(I) three visits during the first trimester;~~

~~(II) three visits during the second trimester; and~~

~~(III) eight visits during the third trimester.~~

(ii) If the clinic does not compensate its practitioners to provide ~~maternity~~ obstetrical care, then the

independent practitioner must bill the ~~Medicaid program for obstetrical care according to the method described in the Medicaid provider specific fee-for-service rules for physicians, nurse midwives and advanced practice nurses~~ 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).~~ (Physician Assistants are excluded from billing the Medicaid program as individual practitioners.)~~

(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.

~~(iv) A standard profile of routine obstetrical lab services may be billed separately. The appropriate revenue code and CPT codes are used.~~

(B) **Family planning services.** Family planning services are ~~paid on an encounter basis. Coverage of family planning service~~ available only to ~~women~~ members with reproductive capability~~ between the child bearing age of 12 and 50~~. Family planning ~~encounters~~ visits do not count as one of the ~~two~~ four RHC visits per month.

~~(i) A family planning visit includes a physical examination, counseling and prescribing appropriate medications and/or contraceptive methods.~~

~~(ii) Prescribed contraceptives may be billed independently from the family planning encounter.~~

(2) **Other ambulatory services.** Services defined as "other ambulatory" services are not considered a part of a RHC ~~encounter~~ visit and are therefore billable to the ~~Medicaid~~ 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 ~~Medicaid~~ 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, ~~through~~ 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the ~~Medicaid fee-for-services~~ SoonerCare program. ~~Refer to OAC 317:30-3-51 for exceptions under EPSDT.~~ Some specific limitations are applicable to other ambulatory services as set forth in ~~Specific Provider Rules~~ 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~~.~~)

B. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
OAC 317:30-5-22. through 317:30-5-22.1. [AMENDED]
(Reference APA WF # 08-12)

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: (1) allow reimbursement of one non stress test and/or one biophysical profile to a Maternal Fetal Medicine (MFM) specialist without requiring a prior authorization; and (2) remove the OB signature requirement from the high risk OB treatment plan form unless the OB provider wishes to request authorization of the ante partum management fee. If the current obstetrical and high risk pregnancy rules are not revised, providers will not be reimbursed for non stress and biophysical profiles performed on SoonerCare members prior to them being determined high risk and SoonerCare members will continue to experience treatment delays that may negatively impact their pregnancy.

SUMMARY: Physician rules are revised to: (1) allow reimbursement of one non stress test and/or one biophysical profile to a Maternal Fetal Medicine (MFM) specialist without requiring a prior authorization; and (2) remove the OB signature requirement from the high risk OB treatment plan form unless he or she wishes to request authorization of the ante partum management fee. Prior to the addition of enhanced services for medically high risk pregnancies, SoonerCare did not cover non stress tests or biophysical profiles. Currently, non stress tests and biophysical profiles are only a covered SoonerCare benefit if the member has a high risk diagnosis and the tests are part of a prior authorized high risk OB treatment plan. According to our medical staff, as well as several MFMs, one or both of these procedures is often required to confirm a suspected high risk pregnancy diagnosis. Therefore, we are now proposing to revise the obstetrical care rules at OAC 317:30-5-22. Current rules also require a High Risk OB Treatment Plan/Prior Authorization Request (OHCA CH-17) signed by the primary provider of obstetric care and a MFM in order to access the enhanced services for medically high risk pregnancies. According to OHCA staff, the MFMs are sending in the plan of care with their signature; however, the Medical Authorizations Unit is having difficulty getting the OB provider's signature on the form. Based on current

policy, without both signatures, authorization cannot be granted. This is causing treatment delays that could be potentially detrimental to pregnant SoonerCare members who have been deemed high risk and may require urgent care. OHCA anticipates removal of the OB signature requirement will improve the turn-around-time for authorizations and enable providers to provide more timely care to our members.

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 May 15, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: August 1, 2008, 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:
Physician rules are revised to: (1) allow reimbursement of one non stress test and/or one biophysical profile to a Maternal Fetal Medicine (MFM) specialist without requiring a prior authorization; and (2) remove the OB signature requirement from the high risk OB treatment plan form unless the OB provider wishes to request authorization of the ante partum management fee.

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)~~ (7) 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'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~~ 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~~ 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~~ diplomate 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. Payment may be made for an evaluation and management service and 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 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.

(7) One non stress test and/or biophysical profile to confirm a suspected high risk pregnancy diagnosis. The non stress test and/or biophysical profile must be performed by an active candidate or Board Certified diplomate in Maternal Fetal Medicine.

(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 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) ~~Non-stress~~ Additional non stress tests, unless the pregnancy is determined medically high risk. ~~except as described in~~ 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 ~~surgery~~ surgeon for obstetrical procedures ~~which~~ that include prenatal or post partum care.

(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.

(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 biophysical profiles (additional units ~~must~~ can be prior authorized for multiple fetuses); and

(3) a maximum of 6 repeat ultrasounds not covered under OAC 317:30-5-22(b)(2).

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

(1) ACOG or other comparable comprehensive prenatal assessment;

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

(3) an OHCA ~~CH-17~~ High Risk ~~Ob~~ OB Treatment Plan/Prior Authorization Request (CH-17) signed by ~~the primary provider of obstetric care and~~ a Maternal Fetal Medicine (MFM) specialist ~~who has agreed to provide collaborative care~~.

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

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

(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~~ 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 ante partum management will not be made during an in-patient hospital stay~~ Reimbursement for enhanced at risk ante partum management is not available to physicians who already qualify for enhanced reimbursement as state employed physicians.