CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-42.14. Surgery and diagnostic services

~~(a) **Reimbursement.** Reimbursement is made for selected surgeries performed in an outpatient hospital. When an ambulatory surgery is performed in the inpatient hospital setting, the physician must provide exception rationale justifying the need for an inpatient setting to OHCA medical staff for review.~~

~~(b) **Ambulatory Surgery Center Groups.** The Medicare definition of covered Ambulatory Surgery Center (ASC) facility services includes services furnished on a outpatient basis in connection with a covered surgical procedure. This is a bundled payment that includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use to patients scheduled for surgical procedures. It includes all services and procedures in connection with covered procedures provided by facility personnel and others involved in patient care. These services do not include physician services, or other health services for which payment can be made under other OHCA medical program provisions (e.g., services of an independent laboratory located on the same site as the ASC, prosthetic devices other than intra ocular lenses (IOLs), anesthetist services, DME). (See OAC 317:30-5-565 for items separately billable.)~~

~~(c)~~ (a) **Ambulatory Patient Classification (APC) Groups.** ~~Certain surgical services filed with revenue code series 36X and 49X and that do not fall within an Ambulatory Patient Classification (ASC) group will pay a SoonerCare rate based on Medicare's APC groups. This is not a bundled rate. Other lines on the claim may pay.~~ All outpatient hospital services paid under the Medicare Outpatient Prospective Payment System (OPPS) are classified into groups called Ambulatory Payment Classifications or APCs. Group services identified by Health Care Procedure Coding System (HCPCS) codes and descriptors within APC groups are the basis for setting payment rates under OPPS. Services in each APC are similar clinically and in terms of the resources they require. The payment rate calculated for an APC applies to all of the services assigned to the APC. Depending on the services provided, a hospital may receive a number of APC payments for the services furnished to a member on a single day.

(b) **Reimbursement.** Reimbursement is made for selected services performed in an outpatient hospital. Hospital outpatient services are paid on a rate-per-service basis that

varies according to the Ambulatory Payment Classification (APC) group to which the services are assigned.

~~(d)~~ (c) **Multiple Surgeries.** ~~Multiple surgeries refers to more than one surgical procedure done on the same person on the same day. The multiple surgery rule provides that under certain circumstances the second and subsequent surgeries may be discounted.~~ Multiple procedures furnished during the same visit are discounted. The full amount is paid for the procedure with the highest payment group. Fifty percent is paid for any other surgical procedure(s) performed at the same time if the procedure is subject to discounting based on the status indicator established by Medicare.

(d) **Status indicators**. Status indicators identify whether the service described by a HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged and if payment is subject to discounting. SoonerCare follows Medicare's guidelines for packaged/bundled service costs.

(e) **Minor procedures.** Minor procedures that are normally performed in a physician's office are not covered in the outpatient hospital unless medically necessary.

(f) **Ambulatory Surgery.** When an ambulatory surgery is performed in the inpatient hospital setting, the physician must provide exception rationale justifying the need for an inpatient setting to OHCA medical staff for review.

~~(f)~~(g) **Dental Procedures.** ~~Dental services are routinely rendered in the dental office, unless the situation requires that the dental service be performed in the outpatient hospital setting. However, services are not covered in the outpatient hospital setting for the convenience of the dentist or member. Dental procedures are not covered as Medicare ASC procedures.~~ Routine dental procedures that are normally performed in a dentist's office are not covered in an outpatient hospital setting unless medically necessary as determined by OHCA. For OHCA payment purposes, the ~~ASC~~ APC list has been expanded to cover ~~these~~ dental services for adults in an ICF/MR and all children.

(1) Non-emergency routine dental that is provided in an outpatient hospital setting is covered under the following circumstances:

(A) The child has a medical history of uncontrolled bleeding or other medical condition which renders in-office treatment impossible.

(B) The child has uncontrollable behavior in the dental office even with premedication.

(C) The child needs extensive dental procedures or oral surgery procedures.

(2) Non-emergency routine dental that is provided in an outpatient hospital setting is covered for children and/or

adults who are residents in ICFs/MR only under the following circumstances ~~for children or adults who are residents in ICFs/MR~~:

~~(1)~~ (A) A concurrent hazardous medical condition exists;

~~(2)~~ (B) The nature of the procedure requires hospitalization or;

~~(3)~~ (C) Other factors (e.g. behavioral problems due to mental impairment) necessitate hospitalization.

~~(g) **Special Procedures**. Certain procedures rendered in a designated area of a licensed hospital dedicated to specific procedures (i.e, Cardiac Catheterization Lab, etc.) are covered and are not paid at a bundled rate. When multiple APC procedures are performed in the same visit, payment will be the rate of the procedure in the highest payment group.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 63. AMBULATORY SURGICAL CENTERS

317:30-5-565. Eligible providers

~~All eligible ambulatory surgical center providers must be certified by Medicare and have a current contract with the Oklahoma Health Care Authority. (1) **Definition of ambulatory surgical center.**~~ An ambulatory surgical center (ASC) is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients~~, and which enters into an agreement with HCFA to do so~~. All eligible ambulatory surgical center providers must be certified by Medicare and have a current contract with the Oklahoma Health Care Authority. ~~An ASC may be either independent (i.e., not part of a provider of services or any other facility), or may be operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). If an ASC is the latter type it has the option of being covered and certified under Medicare as an ASC, or of being covered as an outpatient hospital facility. In order to be covered as an ASC operated by a hospital, a facility must:~~

~~(A) elect to do so, and continue to be so covered unless HCFA determines there is good cause to do otherwise;~~

~~(B) be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital; and~~

~~(C) meet all the requirements with regard to health and safety, and agree to the assignment, coverage and reimbursement rules applied to independent ASC's.~~

~~(2) **Federal requirements.** In order to be eligible to enter into an agreement with HCFA to be covered as an ASC, a~~

~~facility must be surveyed and certified as complying with the conditions for coverage for ASC's in 42 CFR 416.39-49.~~

317:30-5-566. ~~Outpatient surgery~~ Ambulatory Surgery Center services

(a) ~~The covered facility services are defined as those services furnished by an Ambulatory Surgical Center (ASC) or Outpatient Hospital Facility (OHF) in connection with a covered surgical procedure.~~ **Reimbursement**. Reimbursement is made for selected services based on the Medicare approved list of covered services that can be performed at an ASC. Ambulatory surgery center services are paid on a rate-per-service basis that varies according to the Health Care Procedure Coding System (HCPCS) codes. Separate payments may be made to the ASC for covered ancillary services. To be considered a covered ancillary service for which separate payment is made, the items and services must be provided integral to covered surgical procedures, that is, immediately before, during, or immediately after the covered surgical procedure.

~~(1) **Services included in the facility reimbursement rates are:**~~

~~(A) Nursing, technicians, and other related services. These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the facility. In addition to the nursing staff, this category would include orderlies and others involved in patient care.~~

~~(B) Use by the member of the facility. This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.~~

~~(C) Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment. This category includes all supplies and equipment commonly furnished by the facility in connection with surgical procedures including any drugs and biologicals administered while the member is in the facility. Surgical dressings, other supplies, splints, and casts include only those furnished by the facility at the time of surgery. Additional supplies and materials furnished later would generally be furnished as incident to a physician's service and not as a facility service. Supplies include those required for both the member and facility personnel, i.e., gowns, masks, drapes, hoses, scalpels, etc., whether disposable or reusable.~~

~~(D) Diagnostic or therapeutic items and services directly related to the surgical procedures. Payment to the facility includes items and services furnished by facility staff in connection with covered surgical procedures. These diagnostic tests include but are not limited to tests such as urinalysis, blood hemoglobin or hematocrit, CBC and fasting blood sugar, etc.~~

~~(E) Administrative, recordkeeping and housekeeping items and services. These include the general administrative functions necessary to run the facility, such as scheduling, cleaning, utilities, rent, etc.~~

~~(F) Blood, blood plasma, platelets, etc. Under normal circumstances, blood and blood fractions furnished during the course of the procedure will be included in the payment for the facility charge. In cases of patients with congenital or acquired blood disorders, additional payment can be made within the scope of the Authority's Medical Programs.~~

~~(G) Materials for anesthesia. These include the anesthetic and any materials necessary for its administration.~~

~~(2)~~ **~~Services not included in facility reimbursement rates are:~~**

~~(A) Physicians' services. This category includes most services performed in the facility which are not considered facility services. The term physicians' services includes any pre/post-operative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, or other services which the individual physician usually includes in a set global fee for a given surgical procedure.~~

~~(B) The sale, lease or rental of durable medical equipment (DME) to members for use in their homes. If the facility furnishes items of DME to members it should be treated as a DME supplier and this requires a separate contract and separate claim form. Coverage of DME is limited to the scope of the Authority's Medical Programs.~~

~~(C) Prosthetic devices. Non-implantable Prosthetic devices, whether implanted, inserted, or otherwise applied by covered surgical procedures are not included in the facility payment. One of the more common prostheses is intra ocular lenses (IOL's). These should be billed as a separate line item.~~

~~(D) Ambulance services. If the facility furnishes ambulance services, they are covered separately as ambulance services if otherwise compensable under the~~

~~Authority's Medical Programs. This requires a separate contract and a separate claim form.~~

~~(E) Leg, arm, back and neck braces. These items are not included in the facility payment. Payment is limited to the scope of the Authority's Medical Programs.~~

~~(F) Artificial legs, arms and eyes. This equipment is not considered part of a facility service and is not included in the facility payment rate. Payment is limited to the scope of the Authority's Medical Programs.~~

~~(G) Services of an independent laboratory. Payment for laboratory services is limited to the scope of the Authority's Medical Programs.~~

~~(H) Reimbursement - facility services. The facility services are reimbursed according to the group in which the surgical procedure is listed. If more than one surgical procedure is performed at the same setting, the second and subsequent surgeries may be discounted. Reimbursement will be made at a state-wide payment rate based on Medicare's established groups as adapted for SoonerCare.~~

(b) **Multiple surgeries**. Multiple procedures furnished during the same visit are discounted. The full amount is paid for the procedure with the highest payment rate. Fifty percent is paid for any other procedure(s) performed at the same time if the procedure is subject to discounting based on the discount indicator established by Medicare.

(c) **Payment indicators**. Payment indicators identify whether the service described by a HCPCS code is paid under the ASC methodology and if so, whether payment is made separately or packaged. SoonerCare follows Medicare's guidelines for packaged/bundled service costs.

(d) **Minor procedures.** Minor procedures that are normally performed in a physician's office are not covered in an ambulatory surgery center unless medically necessary and they are on the Medicare list for procedures approved to be performed in an ASC.

(e) **Dental Procedures**. For OHCA payment purposes, the ASC list has been expanded to cover dental services for adults in an ICF/MR and all children.

(1) Non-emergency routine dental that is provided in an ambulatory surgery center is covered for children under the following circumstances:

(A) The child has a medical history of uncontrolled bleeding or other medical condition renders in-office treatment impossible.

(B) The child has uncontrollable behavior in the dental office even with premedication.

(C) The child needs extensive dental procedures or oral surgery procedures.

(2) Non-emergency routine dental that is provided in an ambulatory surgical center is covered for children and/or adults who are residents in ICFs/MR only under the following circumstances:

(A) A concurrent hazardous medical condition exists;

(B) The nature of the procedure requires hospitalization or;

(C) Other factors (e.g. behavioral problems due to mental impairment) necessitate hospitalization.

317:30-5-567. Coverage by category

Payment is made for ambulatory surgical center services as set forth in this Section.

(1) **Children.** Payment is made for children for medically necessary surgical procedures which are included on the Medicare's ~~List of Covered Surgical Procedures~~ list of covered ASC surgical procedures and dental procedures in certain circumstances.

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

(B) Federal 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.

(2) **Adults.** Payment is made for adults for medically necessary surgical procedures which are included on Medicare's ~~the List of Covered Surgical Procedures~~ list of covered ASC surgical procedures.

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