TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-42.14. Surgery

(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) **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.

(d) **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 ~~are paid at a lesser amount~~ may be discounted. ~~When multiple ASCs or APCs are performed in the same operative session, payment will be the rate of the procedure in the highest payment group.~~

(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) **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. For OHCA payment purposes, the ASC list has been expanded to cover these services for children. Non-emergency routine dental that is provided in an outpatient hospital setting is covered only under the following circumstances for children or adults who are residents in ICFs/MR:

(1) A concurrent hazardous medical condition exists;

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

(3) 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.

PART 63. AMBULATORY SURGICAL CENTERS (ASC)

317:30-5-566. Outpatient surgery services

The covered facility services are defined as those services furnished by an ASC or OHF in connection with a covered surgical procedure.

(1) **Services included**~~.~~ ~~Services included~~ **in the facility reimbursement** ~~**rate**~~ **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. 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, ~~reimbursement will be made for only the major procedure~~ 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.

~~(3) **Compensable procedures.** The List of Covered Surgical Procedures in (1) of this Section sets out those procedures for which the Authority will recognize a facility charge if otherwise compensable under the Authority's Medical Programs. If a procedure code is~~

~~not on the list the Authority will not pay a facility charge.~~

~~(A) The inclusion of a procedure on this list does not in any way change any of the overall coverage limitations or exclusions of the SoonerCare program. For instance, the program generally excludes coverage for cosmetic surgery, and sexual reassignment. This list sets out the coverage and payment provisions if the procedure is otherwise compensable.~~

~~(B) The procedures are listed by body system, HCPCS codes, a brief description of the procedure and the applicable group payment rate.~~

~~(C) The HCPCS codes further identify the compensable procedures and should be used in billing~~.