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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 35. RURAL HEALTH CLINICS

317:30-5-354. Definitions

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

"**APRN**" means advanced practice registered nurse.

"**C.F.R.**" means the U.S. Code of Federal Regulations.

"**CLIA**" means the Clinical Laboratory Improvement Amendments.

"**CMS**" means the Centers for Medicare and Medicaid Services.

"**CNM**" means certified nurse midwife.

"Core services" means outpatient services that may be covered when furnished to a patient at the rural health clinic (RHC) or other location, including the patient's place of residence. Services include those defined in OAC 317:30-5-355.2.

"**CP**" means clinical psychologist.

"**CPT**" means current procedural terminology.

"**CSW**" means clinical social worker.

"EPSDT" means the Early and Periodic Screening, Diagnostic and Treatment program for members under twenty-one (21)**.**

"FFS" means the current OHCA's fee-for-service reimbursement rate.

"**HCPCS**" means Healthcare Common Procedure Coding System.

"Marriage and family therapist" means the definition given to the same term in Section 1861(lll)(2) of the Social Security Act (42 U.S.C § 1395x(lll)(2)).

"Mental Health counselor" means the definition given to the same term in Section 1861(lll)(4) of the Social Security Act (42 U.S.C § 1395(lll)(4)).

"**OAC**" means the Oklahoma Administrative Code.

"**OHCA**" means the Oklahoma Health Care Authority.

"Other ambulatory services" means other outpatient health services covered under the Oklahoma Medicaid State Plan other than the core services listed in OAC 317:30-5-355.2.

"**PA**" means physician assistant.

"Physician" means:

(A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry when performing medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury, or a doctor of podiatry when performing medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury, or a chiropractor who meets the qualifications defined in 42 CFR 410.21 when performing the services described in 42 CFR 410.21(b).

"Physicians' services" means professional services that are performed by a physician at the RHC (or are performed away from the Center, excluding inpatient hospital services) whose

agreement with the RHC provides that he or she will be paid by the RHC for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

"**RHC"** means rural health clinic.

"Visit" means a face-to-face encounter between a clinic patient and a physician, Physician Assistant (PA), Advanced Practice Registered Nurse (APRN), Certified Nurse Midwife (CMN), Clinical Psychologist (CP), ~~or~~ Clinical Social Worker (CSW), Marriage and Family Therapist (MFT), or Mental Health Counselor (MHC) whose services are reimbursed under the RHC PPS payment method. Encounters with more than one (1) health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Services delivered via audio-only telecommunications and reimbursed pursuant to the fee-for-service (FFS) fee schedule do not constitute a visit and/or an encounter.

317:30-5-355.2. Covered services

The Rural Health Center benefit package, as described in 42 C.F.R. § 440.20, consists of RHC services and other ambulatory services.

(1) **RHC services.** RHC services are covered when medically necessary and furnished at the clinic or other outpatient setting, including the member's place of residence, delivered via telehealth, or via audio-only telecommunications pursuant to Oklahoma Administrative Code (OAC) 317:30-3-27 and OAC 317:30-3-27.1.

(A) **Core services.** RHC ~~"~~core~~"~~ services include, but are not limited to:

(i) Services furnished by a physician, Physician Assistant (PA), Advanced Practice Registered Nurse (APRN), Certified Nurse Midwife ~~(CMN)~~(CNM), Clinical Psychologist (CP), ~~or~~ Clinical Social Worker (CSW), Marriage and Family Therapist (MFT), or Mental Health Counselor (MHC).

(ii) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, ~~or~~ CSW, MFT, or MHC are covered in accordance with 42 C.F.R §§ 405.2413 and 405.2415, if the service or supply is:

(I) Furnished in accordance with State law;

(II) A type commonly furnished in physicians' offices;

(III) A type commonly rendered either without charge or included in the RHC's bill;

(IV) Furnished as an incidental, although integral, part of a physician's professional services, PA, APRN, CNM, CP ~~or~~ CSW, MFT, or MHC; or

(V) Furnished under the direct supervision of a contracted physician, PA, APRN, or CNM; and

(VI) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(iii) Visiting nurse services to the homebound are covered if:

(I) The RHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;

(II) The services are rendered to members who are homebound;
(III) The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and
(IV) The services are furnished under a written plan of treatment as required by 42 C.F.R § 405.2416.
(iv) Certain virtual communication services.

(B) **Preventive services.** In addition to the professional services of a physician, and services provided by an APRN, PA, and CNM which would be covered as RHC services under Medicare, certain primary preventive services are covered under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of an RHC practitioner who is a clinic employee:
(i) Prenatal and postpartum care;
(ii) Screening examination under the EPSDT program for members under twenty-one (21);
(iii) Family planning services; and
(iv) Medically necessary screening mammography and follow-up mammograms.

(C) **Off-site services.** RHC services provided off-site of the clinic are covered if the RHC has a compensation arrangement with the RHC practitioner. SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The RHC must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the RHC services provided off-site are to be billed to SoonerCare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) **Other ambulatory services.** Other ambulatory services that may be provided by an RHC include non-primary care services covered by the Oklahoma Medicaid State Plan but are not included in the RHC's core services. These services are separately billable and may be provided by the RHC if the RHC meets the same standards as other contracted providers of those services.

(A) Other ambulatory services include, but are not limited to:
(i) Dental services for members under the age of twenty-one (21) provided by a qualified provider other than a licensed dentist;
(ii) Optometric services provided by a qualified provider other than a licensed optometrist;
(iii) Laboratory tests performed in the RHC lab, including the lab tests required for RHC certification;
(I) Chemical examinations of urine by stick or tablet method or both (including urine ketones);
(II) Hemoglobin or hematocrit;
(III) Blood glucose;
(IV) Examination of stool specimens for occult blood;
(V) Pregnancy tests; and
(VI) Primary culturing for transmittal to a certified laboratory.

(iv) Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);
(v) Durable medical equipment;
(vi) Transportation by ambulance;
(vii) Prescribed drugs;
(viii) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
(ix) Specialized laboratory services furnished away from the clinic;
(x) Inpatient services;
(xi) Outpatient hospital services; ~~and~~
(xii) Applied behavior analysis (ABA); and
(xiii) Diabetes self-management education and support (DSMES) services.

(B) Services listed in (2)(A) of this Section, furnished on-site, require a separate provider agreement(s) with the OHCA. Service item (2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

317:30-5-356. Coverage for adults

Payment is made to RHCs for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for one (1) encounter per member per day. Payment is also limited to four (4) visits per member per month. This limit may be exceeded if the SoonerCare Choice member has elected the RHC as his/her/their Patient Centered Medical Home/Primary Care Provider. Preventive service exceptions include:

(A) **Obstetrical care.** An RHC should have a written contract with its physician, PA, APRN, or CNM that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for RHC and other ambulatory services.

(i) If the clinic compensates the physician, PA, APRN, or CNM to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.
(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, PAs, APRNs and CNMs (refer to OAC 317:30-5-22).
(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one (1) of the four (4) RHC visits per month.

(2) **Other ambulatory services.** These services are not considered a part of an RHC visit; therefore, these may be billed to the SoonerCare program by the RHC or service provider on the appropriate claim form. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-

57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows:

~~(A) Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors.~~

~~(B)~~(A) 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.)

317:30-5-359.2. Reimbursement

(a) **Provider-based clinics.** Payments for provider-based clinics will be made for RHC ~~"~~core~~"~~ services listed in OAC 317:30-5-355.2 based on an all-inclusive visit fee established by one of the following:

(1) An interim rate established by calculating a statewide average rate for RHCs in the state; and

(2) The statewide average rate will be updated annually by the increase in the Medicare Economic Index (MEI); or

(3) An Alternative Payment Methodology (APM) established by the RHC periodic rate notification from the Medicare Fiscal Intermediary. In order to receive this rate, the RHC must submit a copy of the periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state. The APM rate cannot be lower than mentioned above in (a)(1) or (a)(2).

(b) **Independent clinics.** Payments for independent clinics will be made for RHC ~~"~~core~~"~~ services listed in OAC 317:30-5-355.2 based on an all-inclusive visit fee established by one of the following:

(1) An interim rate established by calculating a statewide average rate for RHCs in the state; and

(2) The statewide average rate will be updated annually by the increase in the MEI; or

(3) An APM established by the RHCs periodic rate notification from the Medicare Fiscal Intermediary. In order to receive this rate, the RHC must submit a copy of the periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state. The APM rate cannot be lower than mentioned above in (b)(1) or (b)(2).

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-659. Definitions

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

"**APRN**" means advanced practice registered nurse.

"**C.F.R**" means the U.S. Code of Federal Regulations.

"**CLIA**" means the Clinical Laboratory Improvement Amendments.

"**CMS**" means the Centers for Medicare and Medicaid Services.

"**CNM**" means certified nurse midwife.

"Core services" means outpatient services that may be covered when furnished to a patient at the Center or other location, including the patient's place of residence. Services include those defined in OAC 317:30-5-661.1.

"**CPT**" means current procedural terminology.

"**CSW**" means clinical social worker.

"Encounter" or **"visit"** means a face-to-face contact between an approved health care professional as authorized in the FQHC pages of the Oklahoma Medicaid State Plan and an eligible SoonerCare member for the provision of defined services through a Health Center within a twenty-four (24) hour period ending at midnight, as documented in the patient's medical record.

"FFS" means the current OHCA~~'s~~ fee-for-service reimbursement rate.

"FQHC" means Federally Qualified Health Center.

"**HHS**" means the U.S. Department of Health and Human Services.

"**HRSA**" means the Health Resources and Services Administration.

"Licensed behavioral health professional (LBHP)" means any of the following practitioners:

(A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (i) through (vi).

(i) Psychology;

(ii) Social work (clinical specialty only);

(iii) Professional counselor;

(iv) Marriage and family therapist;

(v) Behavioral practitioner; or

(vi) Alcohol and drug counselor.

(C) An advanced practice registered nurse certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(D) A physician assistant who is licensed and in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"Marriage and family therapist (MFT)" means the definition given to the same term in Section 1861(lll)(2) of the Social Security Act (42 U.S.C § 1395x(lll)(2)).

"Mental health counselor (MHC)" means the definition given to the same term in Section 1861(lll)(4) of the Social Security Act (42 U.S.C § 1395(lll)(4)).

"**OAC**" means the Oklahoma Administrative Code.

"**OHCA**" means the Oklahoma Health Care Authority.

"Other ambulatory services" means other health services covered under the Oklahoma Medicaid State Plan other than the core services listed in OAC 317:30-5-661.1.

"**PA**" means physician assistant.

"Physician" means:

(A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry when performing medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury, ~~or~~ a doctor of podiatry when performing medical services that are reasonable and necessary for the diagnosis and

treatment of illness or injury, or a chiropractor who meets the qualifications defined in 42 CFR 410.21 when performing the services described in 42 CFR 410.21(b).

"Physicians' services" means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

317:30-5-661.1. Coverage of core services

Health Center services are covered for SoonerCare adults and children as set forth in this Part, unless otherwise specified.

(1) Services furnished by a physician, PA, APRN, CNM, CP, ~~or~~ CSW, MFT, or MHC.

(2) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, ~~or~~ CSW, MFT, or MHC are covered in accordance with 42 C.F.R '' 405.2413 and 405.2415, if the service or supply is:

(A) Furnished in accordance with State law;

(B) A type commonly furnished in physicians' offices;

(C) A type commonly rendered either without charge or included in the FQHC's bill;

(D) Furnished as an incidental, although integral, part of ~~a~~ physician, PA, APRN, CNM, CP ~~or~~ CSW, MFT, or MHC services; or

(E) Furnished under the direct supervision of a physician, PA, APRN, or CNM; and

(F) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of FQHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(G) "Services and supplies incident to" include but are not limited to services such as minor surgery, reading x-rays, setting casts or simple fractures and other activities that involve evaluation or treatment of a patient's condition. They also include laboratory services performed by the Health Center, specimen collection for laboratory services furnished by an off-site CLIA certified laboratory and injectable drugs.

(3) Visiting nurse services to the homebound are covered if:

(A) The FQHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;

(B) The services are rendered to members who are homebound;

(C) The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services from the FQHC; and

(D) The services are furnished under a written plan of treatment as required by 42 C.F.R ' 405.2416.

(4) Preventive primary services in accordance with 42 C.F.R ' 405.2448;

(5) Medical nutrition services in accordance with OAC 317:30-5-1075 through 317:30-5-1076; and

(6) Preventive primary dental services.

317:30-5-661.5. Health Center preventive primary care services

(a) Preventive primary care services, as described in 42 C.F.R ' 405.2448, are those health services that:

(1) A Health Center is required to provide as preventive primary health services under section 330 of the Public Health Service Act;

(2) Are furnished by or under the direct supervision of a physician, PA, APRN, CNM, CP, CSW, MFT, MHC or other approved health care professional as authorized in the approved FQHC State Plan pages;

(3) Are furnished by a member of the Health Center's health care staff who is an employee of the Center or provides services under arrangements with the Center; and

(4) Includes only drugs and biologicals that cannot be self-administered.

(b) Preventive primary care services which may be paid for when provided by Health Centers include:

(1) Medical social services;
(2) Nutritional assessment and referral;
(3) Preventive health education;
(4) Children's eye and ear examinations;
(5) Prenatal and post-partum care;
(6) Perinatal services;
(7) Well child care, including periodic screening (refer to OAC 317:30-3-65);
(8) Immunizations, including tetanus-diphtheria booster and influenza vaccine;
(9) Family planning services;
(10) Taking patient history;
(11) Blood pressure measurement;
(12) Weight;
(13) Physical examination targeted to risk;
(14) Visual acuity screening;
(15) Hearing screening;
(16) Cholesterol screening;
(17) Stool testing for occult blood;
(18) Dipstick urinalysis;
(19) Risk assessment and initial counseling regarding risks;
(20) Tuberculosis testing for high risk patients;
(21) Clinical breast exam;
(22) Referral for mammography; and
(23) Thyroid function test.
(24) Dental services (specified procedure codes).

(c) Primary care services do not include:

(1) Health education classes, or group education activities, including media productions and publications, group or mass information programs;

(2) Eyeglasses, hearing aids or preventive dental services (except under EPSDT);

(3) Screening mammography provided at a Health Center unless the Center meets the requirements as specified in OAC 317:30-5-900; and

(4) Vaccines covered by the Vaccines for Children program (refer to OAC 317:30-5-14).

317:30-5-664.3. FQHC encounters

(a) FQHC encounters that are billed to the Oklahoma Health Care Authority (OHCA) must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by an authorized health care professional listed in the approved FQHC State Plan pages within the scope of their licensure trigger a Prospective Payment System (PPS) encounter rate.
(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a FQHC within a twenty-four (24) hour period ending at midnight, as documented in the member's medical record. Services delivered via audio-only telecommunications do not constitute an encounter.
(c) An FQHC may bill for one (1) medically necessary encounter per twenty-four (24) hour period when the appropriate modifier is applied. Medical review will be required for additional visits for children. For information about multiple encounters, refer to Oklahoma Administrative Code (OAC) 317:30-5-664.4. Payment is limited to four (4) visits per member per month for adults. This limit may be exceeded if the SoonerCare Choice member has elected the FQHC as his/her/their Patient Centered Medical Home/Primary Care Provider.
(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:

(1) Medical;
(2) Diagnostic;
(3) Dental, medical and behavioral health screenings;
(4) ~~Vision~~Optometry;
(5) Physical therapy;
(6) Occupational therapy;
(7) Podiatry;
(8) Behavioral health;
(9) Speech;
(10) Hearing;
(11) Medically necessary FQHC encounters with a registered nurse or licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3); and
(12) Any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the FQHCs scope of services when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to the services of a physician, PA, APRN, CNM, CP, ~~and~~ CSW, MFT, and MHC are reimbursable within the encounter, as described in 42 C.F.R § 405.2413 and OAC 317:30-5-661.1.
(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

317:30-5-664.5. Federally Qualified Health Center (FQHC) encounter exclusions and limitations

(a) Service limitations governing the provision of all services apply pursuant to Oklahoma Administrative Code (OAC) 317:30. Excluded from the definition of reimbursable encounter core services are:

(1) Services provided by an independently Clinical Laboratory Improvement Amendments certified and enrolled laboratory;
(2) Radiology services including nuclear medicine and diagnostic ultrasound services;
(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate Current Procedural Terminology code. A visit for "lab test only" is not considered a Center encounter;
(4) Medical supplies, equipment, and appliances not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare;
(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service;
(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;
(7) Administrative medical examinations and report services;
(8) Emergency services including delivery for pregnant members that are eligible under the Non-Qualified (ineligible) provisions of OAC 317:35-5-25;
(9) SoonerPlan family planning services;
(10) Long-acting reversible contraceptive devices (devices are not considered part of the FQHC encounter rate and can be billed separately);
(11) Optometry and podiatric services other than ~~for dual eligible for Part B of Medicare~~medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury;
(12) Diabetes self-management education and support (DSMES) services (refer to OAC 317:30-5-1080 through 317:30-5-1084); and
(13) Other services that are not defined in this rule or the Oklahoma Medicaid State Plan.

(b) In addition, the following limitations and requirements apply to services provided by FQHCs:
(1) Physician services are not covered in a hospital; and
(2) Behavioral health case management and psychosocial rehabilitation services are limited to FQHCs enrolled under the provider requirements in OAC 317:30-5-240 and contracted with OHCA as an outpatient behavioral health agency.