

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-22. Obstetrical care

(a) Covered services for adults. Payment is made for obstetrical care that is reasonable and necessary. Obstetrical care should be billed using the appropriate CPT codes for maternity care or delivery. The following limitations apply:

(1) **Assessments.** The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form or form covering the same elements as ACOG, and the most recent version of the Oklahoma Health Care Authority's (OHCA) Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one (1) assessment per provider and no more than two (2) per pregnancy.

(2) **Ultrasounds.** To be eligible for payment, all ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).

(A) One (1) ultrasound will be covered in the first trimester of an uncomplicated pregnancy. Both an abdominal and vaginal ultrasound may be allowed when clinically appropriate and medically necessary. The ultrasound must be performed by a board eligible/board certified obstetrician-gynecologist (OB-GYN), radiologist, or a board eligible/board certified maternal-fetal medicine specialist. In addition, this ultrasound may be performed by a certified nurse midwife (CNM), family practice physician or advanced practice nurse practitioner (APRN) in obstetrics with a certification in OB ultrasonography.

(B) One (1) ultrasound after the first trimester will be covered. This ultrasound must be performed by a board eligible/board certified OB-GYN, radiologist, or a board eligible/board certified maternal-fetal medicine specialist. In addition, this ultrasound may be performed by a CNM, family practice physician, or APRN with certification in OB ultrasonography.

(C) One (1) additional detailed ultrasound is allowed by a board eligible/board certified maternal fetal specialist or general obstetrician with documented specialty training in performing detailed ultrasounds. This additional ultrasound is allowed to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.

(D) Limited obstetrical ultrasounds are covered in an emergency room (ER) setting when medically necessary.

(3) **Standby at cesarean section.** Standby attendance at cesarean section is compensable when billed by a physician or qualified health care provider not participating in the delivery. Payment will not be made to the same provider for both standby and assistant services at a cesarean section.

(4) Multiple gestations.

(A) If multiple fetuses are delivered vaginally, the appropriate delivery code should be billed only once.

(B) If multiple fetuses are delivered via cesarean section, the appropriate delivery code should be billed only once.

(C) If multiple fetuses are delivered vaginally and via cesarean section, only the appropriate cesarean section delivery code should be billed once. If at least one (1) fetus is delivered vaginally and additional fetus(es) are delivered via cesarean section by different providers, each provider should bill the appropriate delivery code once.

(5) Noncovered services. There is no coverage for the following services:

(A) Double set up examinations;

(B) Fetal stress tests for normal pregnancies (see OAC 317:30-5-22.1 for high-risk pregnancy coverage);

(C) Fetal scalp blood sampling; and

(D) Pudendal anesthetic.

(b) Covered services for children. Covered services for children are the same as for adults. Additional procedures may be covered under Early and Periodic Screening, Diagnostic and Treatment (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 OHCA 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. For more information regarding experimental or investigational and clinical trials see OAC 317:30-3-57.1.

~~(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 OB care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total OB 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 (1) 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 antepartum visits. The antepartum 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 OB care are listed in (1) – (8) of this subsection:~~

~~(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form or form covering same elements as ACOG₂ and the most recent version of the Oklahoma Health Care Authority's (OHCA) Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one (1) assessment per provider and no more than two (2) per pregnancy.~~

~~(2) Medically necessary real time antepartum diagnostic ultrasounds will be paid in addition to antepartum care, delivery, and postpartum OB care under defined circumstances. To be eligible for payment, all ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).~~

- ~~(A) One (1) ultrasound will be covered in the first trimester of an uncomplicated pregnancy. Both an abdominal and vaginal ultrasound may be allowed when clinically appropriate and medically necessary. The ultrasound must be performed by a board eligible/board certified obstetrician gynecologist (OB-GYN), radiologist, or a board eligible/board certified maternal fetal medicine specialist. In addition, this ultrasound may be performed by a certified nurse midwife (CNM), family practice physician or advanced practice nurse practitioner (APRN) in obstetrics with a certification in OB ultrasonography.~~
- ~~(B) One (1) ultrasound after the first trimester will be covered. This ultrasound must be performed by a board eligible/board certified OB-GYN, radiologist, or a board eligible/board certified maternal fetal medicine specialist. In addition, this ultrasound may be performed by a CNM, family practice physician, or APRN with certification in OB ultrasonography.~~
- ~~(C) One (1) additional detailed ultrasound is allowed by a board eligible/board certified maternal fetal specialist or general obstetrician with documented specialty training in performing detailed ultrasounds. This additional ultrasound is allowed to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.~~
- ~~(3) Standby attendance at cesarean section (C-section), for the purpose of attending the baby, is compensable when billed by a physician or qualified health care provider not participating in the delivery.~~
- ~~(4) Anesthesia administered by the attending physician is a compensable service and may be billed separately from the delivery.~~
- ~~(5) Amniocentesis is not included in routine OB care and is billed separately. Payment may be made for an evaluation and management service and a medically indicated amniocentesis on the same date of service. This is an exception to general information regarding surgery found at Oklahoma Administrative Code (OAC) 317:30-5-8.~~
- ~~(6) Additional payment is not made for the delivery of multiple gestations. If one (1) fetus is delivered vaginally and additional fetus(es) are delivered by C-section by the same physician, the higher level procedure is paid. If one (1) fetus is delivered vaginally and additional fetus(es) are 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) Reimbursement is allowed for nutritional counseling in a group setting for members with gestational diabetes. Refer to OAC 317:30-5-1076(5).~~
- ~~(8) Limited OB ultrasounds are covered in an emergency room (ER) setting when medically necessary.~~
- ~~(e) 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 (6) weeks postpartum office visit.~~
- ~~(d) Procedures listed in (1)–(5) of this subsection are not paid or not covered separately from total OB care.~~
- ~~(1) Non-stress test, unless the pregnancy is determined medically high risk. 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 surgeon for OB procedures that include prenatal or postpartum 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) OB coverage for children is the same as for adults. Additional procedures may be covered under Early and Periodic Screening, Diagnostic and Treatment (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 OHCA 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. For more information regarding experimental or investigational and clinical trials see OAC 317:30-3-57.1.~~

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 Oklahoma Health Care Authority (OHCA) must receive prior authorization for medically necessary enhanced benefits which include:
 - (1) Prenatal at risk antepartum management;
 - (2) A combined maximum of five (5) fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses) with one (1) test per week beginning at thirty-two (32) weeks gestation and continuing to thirty-eight (38) weeks; and
 - (3) A maximum of three (3) follow-up ultrasounds not covered under Oklahoma ~~Administrative~~ Code (OAC) 317:30-5-22(b)(2) 317:30-5-22.
- (b) Prior authorization.** To receive enhanced services, the following documentation must be received by the OHCA Medical Authorization Unit for review and approval:
 - (1) A comprehensive prenatal assessment from the American College of Obstetricians and Gynecologist (ACOG) or other comparable comprehensive prenatal assessment; and
 - (2) Appropriate documentation supporting medical necessity from a board eligible/board certified Maternal Fetal Medicine (MFM) specialist, a board eligible/board certified Obstetrician-Gynecologist (OB-GYN), or a board eligible/board certified Family Practice Physician who has completed an Accreditation Council for Graduate Medical Education (ACGME) approved residency. The medical residency program must include appropriate obstetric training, and the physician must be credentialed by the hospital at which they provide obstetrical services in order to perform such services. The documentation must include information identifying and detailing the qualifying high risk condition. Non-MFM obstetrical providers requesting enhanced services are limited to a specific set of diagnoses as outlined on the OHCA website (www.okhca.org).
- (c) Reimbursement.** When prior authorized, enhanced benefits will be reimbursed as follows:
 - (1) Antepartum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request authorization

of the antepartum management fee, the treatment plan must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk antepartum management is not made during an in-patient hospital stay.

(2) Non stress tests, biophysical profiles and ultrasounds [in addition to those covered under OAC 317:30-5-22 (b)(2) (A) through (C) 317:30-5-22] are reimbursed when prior authorized.

(3) Reimbursement for enhanced at risk antepartum management is not available to physicians who already qualify for enhanced reimbursement as state employed physicians.

PART 19. CERTIFIED NURSE MIDWIVES

317:30-5-226. Coverage by category

(a) **Adults.** Payment is made for certified nurse midwife services within the scope of practice as defined by state law including obstetrical care such as antepartum care, delivery, postpartum care, and care of the normal newborn during the first 28 days of life. Services are subject to the limitations described in OAC 317:30-5-22. Obstetrical care should be billed using the appropriate CPT codes for maternity care or delivery.

~~(1) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be 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. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care. Ultrasounds and other procedures reimbursed separately from total obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b).~~

~~(2) For payment of total OB care, the provider 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 provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.~~

(b) **Newborn.** Payment to certified nurse midwives for services to newborn is the same as for adults. A newborn is an infant during the first 28 days following birth.

(1) Providers must use OKDHS Form FSS-NB-1, or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth. A claim may then be filed for charges for the baby under the case number and the baby's name and assigned person code.

(2) Charges billed on the mother's person code for services rendered to the child will be denied.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

317:30-5-229. Reimbursement

In accordance with the Omnibus Budget Reconciliation Act of 1993, effective October 1, 1993, certified nurse midwife services include maternity services, as well as services outside the maternity cycle within the scope of their practice under state law.

(1) Providers must use the NODOS/NB1 form (found on the OHCA website at <https://oklahoma.gov/ohca/providers/forms.html>) for a newborn child delivered by a SoonerCare member. A claim may then be filed for charges for the newborn under the

case number and the newborn's name and assigned person code. Newborn charges billed on the mother's person code will be denied.

(2) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. Reimbursement will be made for services within scope of practice according to the methodology described in the Oklahoma State Plan. ~~The date of delivery should be 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. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider 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 provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.~~

PART 35. RURAL HEALTH CLINICS

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: 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.)

317:30-5-361. Billing

(a) **Encounters.** Payment is made for one (1) encounter per member per day. Encounters with more than one (1) health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Medical review will be required for additional visits. RHCs must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

(1) **RHC.** The appropriate revenue code is required. No HCPCS or CPT code is required.

(2) **Mental health.** Mental health services must include a revenue code and a HCPCS code.

(3) **Obstetrical care.** The appropriate revenue code and HCPCS code are required. ~~The date the member is first seen is required.~~ The primary pregnancy diagnosis code is ~~also~~ required. Secondary diagnosis codes are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.

(4) **Family planning.** Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.

(5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the CPT Manual. Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist for members under the age of twenty-one (21).

(6) **Dental.** Dental services for children must be billed on the appropriate dental claim form.

(A) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.

(B) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.

(7) **Visual analysis.** Visual analysis services for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Visual analysis services are billed using the appropriate revenue code and a HCPCS code. Payment is made directly to the RHC on an encounter basis for on-site optometric services by a licensed optometrist for members under the age of twenty-one (21).

(b) **Services billed separately from encounters.**

(1) Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges from the physical location where services were rendered/performed.

(A) **Laboratory.** The RHC must be CLIA certified for specialized laboratory services performed. Laboratory services must be itemized separately using the appropriate CPT or HCPCS code.

(B) **Radiology.** Radiology must be identified using the appropriate CPT or HCPC code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.

(C) **Immunizations.** The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.

(D) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required.

(E) **Eyeglasses.** Eyeglasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code. Payment is limited to two eyeglasses per year. Any eyeglasses beyond this limit must be prior authorized and determined to be medically necessary.

(2) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.8. Obstetrical care provided by Health Centers

(a) **Billing written agreement.** In order to avoid duplicative billing situations, a Health Center must have a written agreement with its physician, certified nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how obstetrical care will be billed. The agreement must specifically identify the service provider's compensation for Health Center core services and other health services that may be provided by the Health Center.

(b) **Prenatal or postpartum services.**

(1) If the Health Center compensates the physician, certified nurse midwife or advanced practice nurse for the provision of obstetrical care, then the Health Center bills the Oklahoma Health Care Authority (OHCA) for each prenatal and postpartum visit separately using the appropriate Current Procedural Terminology (CPT) evaluation and management code(s) as provided in the Health Center billing manual.

(2) If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must bill the OHCA for prenatal care according to the ~~global~~ method described in the SoonerCare Traditional provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses [refer to Oklahoma Administrative Code (OAC) 317:30-5-22].

~~(3) 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.~~

(c) **Delivery services.** Delivery services are billed using the appropriate CPT codes for delivery. If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must be individually enrolled and bill for those services using his or her assigned provider number. The costs associated with the delivery must be excluded from the cost settlement/encounter rate setting process.

PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN INDIAN CLINICS (I/T/Us)

317:30-5-1095. I/T/U services not compensable under outpatient encounters

I/T/U services that are not compensable under outpatient encounters include:

- (1) group or mass information programs, health education classes, or group education activities, including media productions and publications;
- (2) vaccines covered by the Vaccines for Children program [refer to Oklahoma Administrative Code 317:30-5-14(a)(1)];
- (3) group or sports physicals and medical reports;
- (4) drug samples or other prescription drugs provided to the clinic free of charge;
- (5) administrative medical examinations and report services; and
- (6) gauze, band-aids, or other disposable products used during an office visit; and
- ~~(7) billing global obstetrical care when performing a cesarean or vaginal delivery only.~~

317:30-5-1099. I/T/U service limitations and requirements

Service limitations governing the provision of all Oklahoma SoonerCare services will apply pursuant to Chapter 30 of the OHCA rules. In addition, the following limitations and requirements apply to services provided by I/T/U facilities:

- (1) **Multiple encounters.** An I/T/U facility may bill for more than one encounter per twenty-four (24) hour period under certain conditions.
- (2) **Behavioral Health services.** Behavioral Health Services are limited to those services furnished to members at or on behalf of the I/T/U facility.
- (3) **Laboratory procedures.** Laboratory procedures performed by an I/T/U outpatient facility (not an independently certified enrolled laboratory) on the same date of service are considered part of the health care practitioner's service and are included in the I/T/U encounter.
- (4) **Obstetrical services.** For OB services provided to a member before, during, and/or after the same pregnancy, ~~ITUs may not bill for individual encounters and the package/bundled rate. Providers may only either:~~
 - ~~(A) bill for antepartum visits, postpartum visits, and/or a cesarean or vaginal delivery as individual encounter; or~~
 - ~~(B) bill the packaged/bundled rate for total care obstetrics, (which includes antepartum and postpartum visits and delivery). Refer to Oklahoma Administrative Code 317:30-5-22 for more detailed obstetrical care policy.~~

PART 115. LICENSED MIDWIVES

317:30-5-1237. Reimbursement

(a) **Payment.** Payment for covered services (as described in OAC 317:30-5-1226) to eligible providers (as described in OAC 317:30-5-1225) shall be made when the same service would have been covered if ordered or performed by a physician. Payment to licensed midwives is made at 80% of the physician fee schedule for the rendered service. Payment for lab and imaging services ordered by licensed midwives is made at 100% of the physician fee schedule.

(b) **Billing.**

(1) **Adults and children.** Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. ~~The date of delivery should be 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. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider 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 provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.~~

(2) **Newborns.** Providers must complete the NODOS/NB1 form (found on the OHCA website at <https://oklahoma.gov/ohca/providers/forms.html>) for a newborn child delivered by a SoonerCare member. A claim may then be filed for charges for the newborn under the case number and the newborn's name and assigned person code. Charges billed on the mother's person code for services rendered to the child will be denied.