AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

4b. Early and Periodic Screening, Diagnosis and Treatment of Conditions Found (continued)

B. Diagnosis and Treatment

The following diagnosis and treatment services are provided in addition to any diagnosis and treatment services covered elsewhere in the plan:

1. **Medical or Other Remedial Care by Licensed Practitioners (42 CFR 440.60)**
   - **(a) Optometric Services –** Services for defects in vision including eyeglasses by State licensed optometrist.
   - **(b) Podiatrists Services –** Payment is made for medically necessary surgical procedures and medically necessary outpatient visits; and procedures generally considered as preventive foot care. Services beyond this limitation are available if as a result of a screening they are determined to be medically necessary and prior authorized.
   - **(c) Nursing Services –** Nursing services may include the provision of services to protect the health status of infants and toddlers, correct health problems, and assist in removing or modifying health related barriers and must be provided by a registered nurse or licensed practical nurse under supervision of a registered nurse. Services may include medically necessary procedures rendered in the child's home.
   - **(d) Licensed Behavioral Health Practitioner Services –** Services provided under the scope of their licensure by clinical psychologists and master's level behavioral practitioners who can bill independently using the appropriate Physician's Current Procedure Terminology (CPT) codes in an outpatient setting**.** Services may include family therapy that is evidence-based or best practice psychosocial interventions (psychoeducation) provided by individuals with demonstrated training and credentials for conducting such services.
   - **(e) Applied Behavior Analysis (ABA) Services (EPSDT only) –** ABA services include the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services must be medically necessary and prior authorized by OHCA or its designated agent. Eligible ABA provider types include:
     - i. **Board Certified Behavior Analyst (BCBA) –** A master's or doctoral level independent practitioner who is certified by the nationally accredited BACB and licensed by DHS DDS to provide behavior analysis services. A BCBA may supervise the work of BCaBA's implementing behavior analytic interventions.
     - ii. **Board Certified Assistant Behavior Analyst (BCaBA) –** A bachelor's level practitioner who is certified by the nationally accredited Behavior Analyst Certification Board (BACB) and is certified by the Oklahoma Department of Human Services (DHS) Developmental Disabilities Services (DDS) to provide behavior analysis services under the supervision of a BCBA; and
     - iii. **State-licensed human services professional –** An Oklahoma state-licensed or certified individual practicing within the scope of their human service profession as defined by State law and who is certified by the nationally accredited BACB, to include:
       - (A) A licensed physical therapist;
       - (B) An occupational therapist;
       - (C) A licensed clinical social worker or licensed masters social worker;
       - (D) A psychologist;
       - (E) A speech-language pathologist or audiologist;
       - (F) A licensed professional counselor or licensed professional counselor candidate;
       - (G) A licensed marital and family therapist or licensed marital and family therapist candidate; or
       - (H) A licensed behavioral practitioner or licensed behavioral practitioner candidate.

2. **Medical supplies, equipment, appliances and prosthetic devices (42 CFR 440.70 & 42 CFR 440.120).** Services and supplies not otherwise available to Medicaid clients in the state under the state plan when prior authorized.

3. **Diagnostic Services (42 440.130(a))**
   (a) Investigations to Determine Source of Lead. A one-time investigation to determine the source of lead for a child diagnosed with elevated blood lead levels. Reimbursement does not include testing the water, soil, or paint. In accordance with the rules established by the Oklahoma Department of Environmental Quality (DEQ)**,** a qualified Risk Assessor must perform the service.

4. **Clinic Services (42 CFR 440.90)**
   (a) Public Health Clinic Services

DATES FOR ESTABLISHING PAYMENT RATES FOR ATTACHMENT 4.19-B SERVICES

Effective Dates for Reimbursement Rates for Specified Services: *(continued)*

Service	State Plan Page	Effective Date
4.b. EPSDT *(continued)* • Other Practitioner – Applied Behavior Analysis (ABA) Services	Attachment 4.19-B, Page 28.13	July 1, 2019
Christian Science Nurses	Attachment 4.19-B, Page 28.5	October 1, 2018
Dentures	Attachment 4.19-B, Page 28.6	October 1, 2018
Respiratory Care	Attachment 4.19-B, Page 28.7	October 1, 2018
Private Duty Nursing Services	Attachment 4.19-B, Page 28.8	October 1, 2018
Physical Therapist	Attachment 4.19-B, Page 28.9	October 1, 2018
Occupational Therapist	Attachment 4.19-B, Page 28.10	October 1, 2018
Christian Science Sanatoria	Attachment 4.19-B, Page 28.11	October 1, 2018
Other Practitioner – Licensed Clinical Social Worker	Attachment 4.19-B, Page 28.12	October 1, 2018
Pediatric or Family Nurse Practitioner (Advanced Practice Nurse) Services	Attachment 4.19-B, Page 32	October 1, 2018

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

REIMBURSEMENT FOR INDIAN HEALTH SERVICE, TRIBAL PROGRAMS, AND URBAN CLINICS

For services provided to Native Americans by a qualified facility operated by the Indian Health Service, tribal government(s), or urban Indian health program (ITU), the applicable Office of Management and Budget (OMB) rate will be paid as published and specified in the Federal Register.

Alternative Payment Methodology for Reimbursement of Indian Health Services and Tribal 638 Facilities contracted as FQHCs

For qualified facilities operated by ITU providers that contract with the Medicaid agency as an FQHC, hereafter referred to as ITU-FQHC, an alternate payment method (APM) is allowed. The APM rate for services provided by an ITU-FQHC is set at the OMB rate.

The rate for services will be the same for both AI/AN and non-AI/AN.

For purposes of being recognized as an FQHC by Medicaid, Tribal facilities need not meet any requirement other than being operated by a Tribe or Tribal organization under P.L. 93-638.

Encounter reimbursement of ITUs & ITU/FQHCs

Reimbursement is made for an individual medical, dental, and outpatient behavioral health encounter per member per day. Reimbursement for more than one outpatient visit within a 24-hour period is made when services are provided for a distinctly different diagnosis.

Certain services provided by an ITU or ITU-FQHC are not eligible for the OMB rate reimbursement. These services provided by the ITU or ITU-FQHC are not to be considered in calculations pertaining to the OMB rate. In such cases the Agency will reimburse the ITU or ITU-FQHC at the Oklahoma Medicaid Fee Schedule rate. These services are:

(a) Applied behavioral analysis (ABA) services referenced at 4b.B.1.(e). within Attachment 3.1-A, Page 1a-6.1.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for Rural Health Clinic Services and Other Ambulatory Services furnished by Rural Health Clinics

Effective January 1, 2001 payments to Rural Health Clinics (RHCs) for Medicaid covered services during RHC fiscal year 2001 will be paid on a per visit basis. The methodology described below is in accordance with the provisions of the Benefits Improvement and Protection Act (BIPA) of 2000.

A per visit rate for each facility will be determined based on 100 percent of the average facility's reasonable costs for providing all Medicaid covered services (including other ambulatory services) during RHC fiscal year 1999 and RHC fiscal year 2000. RHC fiscal year means cost reports ending in 1999 and 2000. The averaging methodology is as follows: total costs for 1999 and 2000 will be added together and divided by the number of visits.

The per-visit rate will be adjusted to account for any increase or decrease in the scope of services furnished during RHC fiscal year 2001. This adjustment will be calculated based on a review of available financial or statistical information, including data submitted on cost reports and special surveys to calculate any base rate adjustment. Each facility will be responsible for supplying the needed documentation to the OHCA

Beginning with RHC fiscal year 2002 and each RHC fiscal year thereafter, each facility's per visit rate will be inflated by the percentage increase in the Medicare Economic Index (MEI) for primary care services. Each facility's per visit rate will also be adjusted to account for any increase or decrease in the scope of services using the methodology described in paragraph 3 above.

Rural Health Clinics that enroll in Medicaid after RHC fiscal year 2000 will have their initial per visit rate established either by reference to payments to other Rural Health Clinics in the same or adjacent areas, or in the absence of such other clinics, through cost reporting methods. After the initial year, the per-visit rate shall be established using the facility's reasonable costs inflated by the increase in the MEI.

Supplemental payments will be made to Rural Health Clinics that subcontract directly or indirectly with managed care entities. Payments will represent the difference paid by the entities and the payment to which the Rural Health Clinics would be entitled under a prospective pay per visit rate. Payments will be made quarterly.

Certain services provided by a RHCs are not eligible for the facility's per visit rate. These services provided by the RHC are not to be considered in calculations pertaining to the facility's per visit rate. In such cases, the Agency will reimburse the RHC at the Oklahoma Medicaid Fee Schedule rate. These services are:

(a) Applied behavioral analysis (ABA) services referenced at 4b.B.1.(e). within Attachment 3.1-A, Page 1a-6.1.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for Federally Qualified Health Center Services ~~(Cont.)~~ *(continued)*

Effective for services provided on or after June 1, 2012, the PPS payment methodology is available for services provided by Licensed Professional Counselors (LPC), Licensed Alcohol and Drug Counselors (LADC), Licensed Marital and Family Therapist (LMFT) and Licensed Behavioral Professionals (LBP) employed by or contracted by FQHCs who provide behavioral health services to children in accordance with the Oklahoma State Plan and HRSA grant award authority or Notice of Look-alike Designation (NLD).

Certain services provided by a FQHC are not eligible for PPS rate reimbursement. These services provided by the FQHC are not to be considered in calculations pertaining to the PPS rate. In such cases, the Agency will reimburse the FQHC at the Oklahoma Medicaid Fee Schedule rate. These services are:

Applied behavioral analysis (ABA) services referenced at 4b.B.1.(e). within Attachment 3.1-A, Page 1a-6.1.

Scope-of-Service Rate Adjustments

An FQHC may apply for an adjustment to the per-visit rate or the State may review and adjust the per visit rate based on a change in the scope-of-services provided by the FQHC. A change in scope-of-service means any of the following:

(a) The addition of a new FQHC service (such as adding medical, dental or behavioral health services or another health professional service), or deletion of SoonerCare covered services that are included in the existing prospective payment system reimbursement rate.

(b) A change in service due to amended regulatory requirements or rules.

(c) A change in service resulting from either remodeling an FQHC or relocating an FQHC if it has not elected to be treated as a newly qualified clinic.

(d) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(e) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services provided, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(f) A change in the scope of a project approved by HRSA where the change impacts a covered service.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

4b. Early and Periodic screening, diagnostic and treatment *(continued)*

Applied Behavior Analysis (ABA) Services

Payment for ABA services is made in accordance with the methodology described in Attachment 4.19-B, Page 3.