

Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's [Proposed Changes Blog](#).

OHCA COMMENT DUE DATE: February 24, 2020

The proposed policy changes are currently in effect as Emergency Rules and must be promulgated as Permanent Rules. The proposed policy was presented at the January 8 and November 5, 2019 and to the Medical Advisory Committee on November 7, 2019. Additionally, this proposal will be presented at a Public Hearing on February 19, 2020 and to the OHCA Board of Directors on March 18, 2020.

Reference: APA WF # 19-03

SUMMARY:

Applied Behavior Analysis (ABA) services - The proposed rule changes will add new language establishing coverage and reimbursement for ABA services as an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. The proposed language will define scope of service, provider criteria and credentialing requirements, medical necessity, prior authorization and extension requests for continued services. Other revisions will involve limited rewriting aimed at clarifying medical necessity criteria and updating outdated policy sections.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

TO: Maria Maule
Legal Services

FROM: Vanessa Andrade
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 19-03

A. Brief description of the purpose of the rule:

The proposed rule changes will establish coverage and reimbursement for ABA services as an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. The proposed language will define scope of service, medical necessity, prior authorization and extension requests for continued services. The proposed rule changes will define provider criteria and credentialing requirements for Board Certified Behavior Analyst® (BCBA®), Board Certified Assistant Behavior Analyst® (BCaBA®), Registered Behavior Technician™ (RBT®) and human services professionals. Additionally, SoonerCare will set prior authorization limits for ABA treatment. Authorizations will be granted for up to thirty (30) hours per week within a six (6) month period. SoonerCare recognizes that in some cases additional hours may be medically necessary; therefore, providers must submit a prior authorization request with supporting documentation for a secondary medical review. Other revisions will involve limited rewriting aimed at clarifying medical necessity criteria and updating outdated policy sections.

Finally, the proposed rule changes will clarify how Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us) obstetrical (OB) providers should bill for OB care. I/T/Us have the option of either billing for OB encounters or a bundled rate for total OB care. The clarification will require I/T/Us to be specific when choosing a billing method as they are only allowed to choose one of the billing methods. Finally, the proposed changes will establish new service limitations and requirements for OB services. The proposed rule change related to I/T/Us OB providers included in this work folder is part of WF 19-33 Indian Health Services Tribal Programs, and Urban Indian Clinics which was approved by the Board on January 22, 2020.

- B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

No classes of person will be affected by the proposed rule.

- C. A description of the classes of persons who will benefit from the proposed rule:

The proposed rule changes will benefit SoonerCare members under twenty-one (21) diagnosed with Autism Spectrum Disorder (ASD) and who meet the eligibility criteria for the provision of ABA services under the EPSDT benefit. The proposed revisions will

increase access to care for ABA services.

- D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable impact of the proposed rule upon any classes of persons or political subdivisions.

- E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The proposed rule changes will not result in any additional costs and/or savings to the agency. Budget allocation to establish coverage of and reimbursement for ABA services, including services rendered by RBTs, was approved during promulgation of the first emergency rule on July 1, 2019.

The proposed rule changes to clarify how I/T/U OB providers should bill for OB care will not result in any cost and/or savings to the agency.

- F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

- G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule changes will not have an adverse effect on small business.

- H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

- I. A determination of the effect of the proposed rule on the public

health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule changes should have no adverse effect on the public health, safety, and environment.

- J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

- K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared: November 27, 2019

Modified: January 24, 2020

RULE TEXT:

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

**PART 4. EARLY AND PERIODIC SCREENING, ~~DIAGNOSIS~~DIAGNOSTIC
AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES**

317:30-3-65.12. Applied behavior analysis (ABA) services

(a) Purpose and general provisions. The purpose of this Section is to establish guidelines for the provision of ABA services under the EPSDT benefit.

(1) ABA focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services include the use of direct observation, measurement, and functional analysis of the relations between the environment and behavior. Common ABA-based techniques include, but are not limited to; discrete trial training; pivotal response training; and verbal behavioral intervention.

(2) ABA may be provided in a variety of settings, including home, community, or a clinical setting. It involves development of an individualized treatment plan that includes transition and aftercare planning, and significant family/caregiver involvement.

(3) At an initial assessment, target symptoms are identified. A treatment plan is developed that identifies core deficits and aberrant behaviors, and includes designated interventions

intended to address these deficits and behaviors and achieve individualized goals.

(4) Functional behavioral assessment (FBA) may also be a part of any assessment. An FBA consists of:

(A) Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity);

(B) History of the problematic behavior (long-term and recent);

(C) Antecedent analysis (setting, people, time of day, events);

(D) Consequence analysis; and

(E) Impression and analysis of the function of the problematic behavior.

(5) ABA services require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-3-65.12(e)]. These services are designed to accomplish medically necessary management of severe and complex clinical conditions that within a finite and reasonable period of time, the caregiver will be able to demonstrate knowledge and ability to independently and safely carry out the established plan of care.

(b) **Eligible providers.** Eligible ABA provider types include:

(1) Board certified behavior analyst® (BCBA®) - A master's or doctoral level independent practitioner who is certified by the national-accrediting Behavior Analyst Certification Board, Inc.® (BACB®) and licensed by Oklahoma Department of Human Services' (OKDHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services. A BCBA may supervise the work of board certified assistant behavior analysts and registered behavior technicians implementing behavior analytic interventions;

(2) Board certified assistant behavior analyst® (BCaBA®) - A bachelor's level practitioner who is certified by the national-accrediting BACB and certified by OKDHS DDS to provide behavior analysis services under the supervision of a BCBA;

(3) Registered behavior technician™ (RBT®) - A high school level or higher paraprofessional who is certified by the national-accrediting BACB and practices under the close and ongoing supervision of a BCBA. The RBT works under the license number of a BCBA and is primarily responsible for the direct implementation of BCBA designed and prescribed behavior-analytic services; and

(4) Human services professional - A practitioner who is licensed by the State of Oklahoma pursuant to (A) - (H), and certified by the national-accrediting BACB, and who is working within the scope of his or her practice, to include:

(A) A licensed physical therapist;

(B) A licensed occupational therapist;

(C) A licensed clinical social worker or social worker candidate under the supervision of a licensed clinical social worker;

- (D) A licensed psychologist;
- (E) A licensed speech-language pathologist or licensed audiologist;
- (F) A licensed professional counselor or professional counselor candidate under the supervision of a licensed professional counselor;
- (G) A licensed marital and family therapist or marital and family therapist candidate under the supervision of a licensed marital and family therapist; or
- (H) A licensed behavioral practitioner or behavioral practitioner candidate under the supervision of a licensed behavioral practitioner.

(c) **Provider criteria.** To direct, supervise, and/or render ABA services, the following conditions shall be met.

(1) A BCBA shall:

- (A) Be currently licensed by OKDHS DDS as a BCBA;
- (B) Have no sanctions or disciplinary actions by OKDHS DDS or the BACB;
- (C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
- (D) Be fully contracted with SoonerCare as a provider.

(2) A BCaBA shall:

- (A) Be currently certified by OKDHS DDS as a BCaBA;
- (B) Work under the supervision of a SoonerCare-contracted BCBA provider;
- (C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
- (D) Be fully contracted with SoonerCare as a provider.

(3) An RBT shall:

- (A) Be currently certified by the national-accrediting BACB as an RBT;
- (B) Work under the supervision of a SoonerCare-contracted BCBA provider;
- (C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
- (D) Be fully contracted with SoonerCare as a provider.

(4) A human services professional shall:

- (A) Be currently licensed or certified by the State of Oklahoma, in accordance with Section 1928 of Title 59 of the Oklahoma Statutes;
- (B) Be currently certified by the national-accrediting BACB;
- (C) Have no sanctions or disciplinary actions by the applicable state licensing board or the BACB;
- (D) If working under supervision within the scope of his or her practice, have a documented relationship with a fully-licensed human service professional working in a supervisory capacity;

(E) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(F) Be fully contracted with SoonerCare as a provider.

(d) Medical necessity criteria for members under twenty-one (21) years of age. ABA services are considered medically necessary when all of the following conditions are met:

(1) The member is under twenty-one (21) years of age with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers:

(A) Pediatric neurologist or neurologist;

(B) Developmental pediatrician;

(C) Licensed psychologist;

(D) Psychiatrist or neuropsychiatrist; or

(E) Other licensed physician experienced in the diagnosis and treatment of autism.

(2) A comprehensive diagnostic evaluation completed by one (1) of the above identified professionals must:

(A) Be completed within the last two (2) years;

(B) Include a complete pertinent medical and social history, including pre-and perinatal, medical, developmental, family, and social elements; and

(C) Be based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) for ASD and/or may also include scores from the use of formal diagnostic tests such as the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Schedule-2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale.

(3) There must be a reasonable expectation that the member will benefit from ABA. The member must exhibit:

(A) The ability/capacity to learn and develop generalized skills to assist with his or her independence; and

(B) The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD.

(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(5) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities. Such atypical or disruptive behavior may include, but is not limited to:

(A) Impulsive aggression toward others;

(B) Self-injury behaviors; or

(C) Intentional property destruction.

(6) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum

level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.")

(7) It has been determined that there is no less intensive or more appropriate level of services which can be safely and effectively provided.

(e) **Prior authorization.** Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority (OHCA) or its designated agent. Prior authorization requests shall be granted up to six (6) months of ABA treatment services at one (1) time unless a longer duration of treatment is clinically indicated. The number of hours authorized may differ from the hours requested on the prior authorization request based on the review by an OHCA reviewer and/or physician. If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization. The prior authorization request must meet the following SoonerCare criteria for ABA services.

(1) The criteria includes a comprehensive behavioral and functional behavioral assessment outlining the behaviors consistent with the diagnosis of ASD and its associated comorbidities. In addition to completing the initial request form, providers will be required to submit a written assessment that will consist of the following:

(A) Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments.

(B) Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member and the family.

(C) Direct assessment and observation, including any data related to the identified problem behavior. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing and adapting treatment protocols, and evaluating response to treatment and progress towards goals.

(D) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences.

(2) The prior authorization for ABA treatment will be time limited for up to thirty (30) hours per week unless other hours are deemed medically necessary and authorized through a prior

authorization request and must:

(A) Be a one-on-one encounter (face to face between the member and ABA provider) except in the case of family adaptive treatment guidance;

(B) Be child-centered and based upon individualized goals that are strengths-specific, family focused, and community based;

(C) Be culturally competent and the least intrusive as possible;

(D) Clearly define in measurable and objective terms the specific target behaviors that are linked to the function of (or reason for) the behavior;

(E) Record the frequency, rate, symptom intensity/duration, or other objective measures of baseline levels;

(F) Set quantifiable criteria for progress;

(G) Establish and record behavioral intervention techniques that are appropriate to target behaviors. The detailed behavior analytic treatment plan utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;

(H) Specify strategies for generalization of learned skills;

(I) Document planning for transition through the continuum of interventions, services, and settings, as well as discharge criteria;

(J) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care. Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;

(K) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques in the member's medical record. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment; and

(L) Ensure that recommended ABA services do not duplicate or replicate services received in a member's primary academic education setting, or provided within an Individualized Education Plan (IEP), Individualized Service Plan (ISP), or any other individual plan of care.

(f) **ABA extension requests.** Extension requests for ABA services must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish the following:

(1) Eligibility criteria in OAC 317:30-3-65.12(d) 1-6;

(2) The frequency of the target behavior has diminished since last review, or if not, there has been modification of the treatment or additional assessments have been conducted;

(3) If progress has not been measurable after two (2) extension requests, a functional analysis will be completed which records the member's maladaptive serious target behavioral symptom(s), and precipitants, as well as makes a determination of the function a particular maladaptive behavior serves for the member in the environmental context;

(4) Appropriate consultations from other staff or experts have occurred (psychiatric consults, pediatric evaluation for other conditions) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);

(5) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and

(6) The treatment plan documents a gradual tapering of higher intensities of intervention and shifting to supports from other sources (i.e., schools) as progress occurs.

(g) **Reimbursement methodology.** SoonerCare shall provide reimbursement for ABA services in accordance with the Medicaid State Plan.

(1) Payment shall only be made to SoonerCare-contracted groups or qualified individual providers who are currently licensed and in good standing. Payment is not made to under supervision ABA practitioners/paraprofessionals, including but not limited to, BCaBAs and RBTs.

(2) Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.

(3) Reimbursement shall only be made for services that have been prior-authorized by OHCA or its designee; and performed on an individualized basis and not in a group setting except for family adaptive behavior treatment guidance by a qualified ABA provider [OAC 317:30-3-65.12(b)].

(4) Reimbursement for ABA services shall not be made to or for services rendered by a parent, legal guardian, or other legally responsible person.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-2. General coverage by category

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA) SoonerCare program, provided the services are

reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One (1) inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies.

(G) Physician services on an outpatient basis include:

(i) A maximum of four (4) ~~primary care visits per member per month~~ visits per member per month, including primary care or specialty, with the exception of SoonerCare Choice members, ~~or.~~

~~(ii) A maximum of four (4) specialty visits per member per month.~~

~~(iii)~~ (ii) Additional visits are allowed per month for treatment related to emergency medical conditions and family planning services.

(H) Direct physician services in a nursing facility.

(i) A maximum of two (2) nursing facility visits per month are allowed; and if the visit (s) is for psychiatric services, it must be provided by a psychiatrist or a physician with appropriate behavioral health training.

(ii) To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the explanation of Medicare benefits (EOMB) showing denial and mark "carrier denied coverage."

(I) Diagnostic x-ray and laboratory services.

(J) Mammography screening and additional follow-up mammograms as per current guidelines.

(K) Obstetrical care.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure.

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, Oklahoma Department of

Human Services ~~(DHS)~~ (OKDHS) form 08MA016E, Authorization for Examination and Billing, must accompany the claim.

(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.

(O) Family planning includes sterilization procedures for legally competent members twenty-one (21) years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.

(P) Genetic counseling.

(Q) Laboratory testing.

(R) Payment for ultrasounds for pregnant women as specified in Oklahoma Administrative Code (OAC) 317:30-5-22.

(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.

(T) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met:

- (i) Attending physician performs chart review and signs off on the billed encounter;
- (ii) Attending physician is present in the clinic/or hospital setting and available for consultation; and
- (iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(U) Payment for services rendered by medical residents in an outpatient academic setting when the following conditions are met:

- (i) The resident has obtained a medical license or a special license for training from the appropriate regulatory state medical board; and
- (ii) has the appropriate contract on file with the OHCA to render services within the scope of their licensure.

(V) The payment to a physician for medically directing the services of a certified registered nurse anesthetist (CRNA) or for the direct supervision of the services of an anesthesiologist assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been

performed solely by the anesthesiologist.

(W) Screening and follow up pap smears as per current guidelines.

~~(X) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:~~

~~(i) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.~~

~~(ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.~~

~~(iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.~~

~~(iv) Procedures considered experimental or investigational are not covered. Medically necessary organ and tissue transplantation services for children and adults are covered services based upon the conditions listed in (i)-(v) of this subparagraph:~~

~~(v) of this subparagraph:~~

~~(i) All transplantation services, except kidney and cornea, must be prior authorized;~~

~~(ii) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;~~

~~(iii) All organ transplants must be performed at a Medicare-approved transplantation center;~~

~~(iv) Procedures considered experimental or investigational are not covered; and~~

~~(v) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.~~

~~(Y) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.~~

~~(Z)~~ (Y) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure. Donor expenses that occur after the ninety (90) day global reimbursement period must be submitted to the OHCA for review.

~~(AA)~~ (Z) Total parenteral nutritional (TPN) therapy for identified diagnoses and when prior authorized.

~~(BB)~~ (AA) Ventilator equipment.

~~(CC)~~ (BB) Home dialysis equipment and supplies.

~~(DD)~~ (CC) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of

Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy." Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

~~(EE)~~ (DD) Smoking and tobacco use cessation counseling for treatment of members using tobacco.

(i) Smoking and tobacco use cessation counseling consists of the 5As:

- (I) Asking the member to describe their smoking use;
- (II) Advising the member to quit;
- (III) Assessing the willingness of the member to quit;
- (IV) Assisting the member with referrals and plans to quit; and
- (V) Arranging for follow-up.

(ii) Up to eight (8) sessions are covered per year per individual.

(iii) Smoking and tobacco use cessation counseling is a covered service when performed by physicians, physician assistants (PA), advanced registered nurse practitioners (ARNP), certified nurse midwives (CNM), dentists, Oklahoma State Health Department (OSDH) and Federally Qualified Health Center (FQHC) nursing staff, and maternal/child health licensed clinical social worker trained as a certified tobacco treatment specialist (CTTS). It is reimbursed in addition to any other appropriate global payments for obstetrical care, primary care provider (PCP) care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note that addresses the 5A's and office note signature along with the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3) minutes is considered part of a routine visit and not separately billable.

~~(FF)~~ (EE) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

~~(GG)~~ (FF) Genetic testing and other molecular pathology services are covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition, is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified) or has been diagnosed with a condition where identification of specific genetic changes

will impact treatment or management; and

(ii) Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular marker; and

(iv) A medical geneticist, physician, or licensed genetic counselor provides documentation that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Routine eye examinations for the sole purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of lenses, frames or visual aids.

(E) Pre-operative care within twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomies.

(I) Medical services considered experimental or investigational.

(J) Payment for more than four (4) outpatient visits per member (home or office) per month, except visits in connection with family planning, services related to emergency medical conditions, or primary care services provided to SoonerCare Choice members.

(K) Payment for more than two (2) nursing facility visits per month.

(L) More than one (1) inpatient visit per day per physician.

(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing,

tumor board review or multidisciplinary opinion, dictation, and similar functions.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50).

(Q) Speech and hearing services.

(R) Mileage.

(S) A routine hospital visit on the date of discharge unless the member expired.

(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(U) Inpatient chemical dependency treatment.

(V) Fertility treatment.

(W) Payment for removal of benign skin lesions.

(X) Sleep studies.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of twenty-one (21) within the scope of the SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by an agency designated by the OHCA. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) All ~~residential and acute inpatient~~ inpatient psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25, 317:30-5-95.27 and 317:30-5-95.29.

(B) For out of state placements, refer to OAC 317:30-3-89 through 317:30-3-92.

(2) **General acute care**~~Acute~~ inpatient service limitations. All general acute care~~Acute~~ inpatient hospital services for members under the age of twenty-one (21) are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.**

The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.**

Utilization control requirements for inpatient psychiatric services for members under twenty-one (21) years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment (EPSDT) program.** Payment is made to eligible providers for EPDST of members under age twenty-one (21). These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through ~~317:30-3-65.11~~ 317:30-3-65.12 for specific guidelines.

(6) **Reporting suspected abuse and/or neglect.** Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, ~~10A Oklahoma Statute (O.S.) § 1-2-101~~ Section 1-2-101 of Title 10A of the Oklahoma Statutes and ~~43A O.S. § 10-104~~. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services ~~(DHS)~~ (OKDHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local ~~DHS~~ OKDHS county office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the ~~DHS~~ OKDHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

(7) **General exclusions.** The following are excluded from coverage for members under the age of twenty-one (21):

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two (2) physicians for the same type of

service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Pre-operative care within twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by CPT and CMS.

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of members who are under twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(G) Non-therapeutic hysterectomies.

(H) Medical services considered experimental or investigational.

(I) More than one (1) inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50).

(K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Mileage.

(P) A routine hospital visit on date of discharge unless the member expired.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The EOMB reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within ninety (90) days of the date of Medicare payment and within one (1) year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically

"cross over." Providers must file a claim for coinsurance and/or deductible to SoonerCare within ninety (90) days of the Medicare payment and within one (1) year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the EOMB showing the reason for the denial.

PART 35. RURAL HEALTH CLINICS

317:30-5-355.1. Definition of services

The ~~RHC~~Rural Health Clinic (RHC) benefit package, as described in Title 42 of the Code of Federal Regulations ~~(CFR)~~(C.F.R.), part § 440.20, consists of two (2) components: RHC ~~Services and Other Ambulatory Services~~services and other ambulatory services.

(1) **RHC services.** RHC services are covered when furnished to a member at the clinic or other location, including the member's place of residence. These services are described in this Section.

(A) **Core services.** As set out in ~~Federal Regulations at 42 CFR~~C.F.R. § 440.20(b), RHC "core" services include, but are not limited to:

- (i) Physician's services;
- (ii) Services and supplies incident to a physician's services;
- (iii) Services of advanced practice registered nurses ~~(APNs)~~(APRNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;
- (iv) Services and supplies incident to the services of ~~APNs~~APRNs and PAs (including services furnished by ~~certified nurse midwives~~CNMs);
- (v) Visiting nurse services to the homebound;
- (vi) Clinical psychologist (CP) and clinical social worker (CSW) services;
- (vii) Services and supplies incident to the services of CPs and CSWs.

(B) **Physicians' services.** In addition to the professional services of a physician, and services provided by an ~~APN~~APRN, PA, and ~~NM~~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~~an RHC practitioner who is a clinic employee:

- (i) ~~prenatal~~Prenatal and postpartum care;
- (ii) ~~screening~~Screening examination under the Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) Program for members under 21~~twenty-one~~ (21);
- (iii) ~~family~~Family planning services;
- (iv) ~~medically~~Medically necessary screening mammography

and follow-up mammograms ~~when medically necessary.~~

(C) **Services and supplies "incident to".** Services and supplies incident to the service of a physician, ~~physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker~~ PA, APRN, CP, or CSW are covered if the service or supply is:

- (i) ~~a~~A type commonly furnished in physicians' offices;
- (ii) ~~a~~A type commonly rendered either without charge or included in the rural health clinic's bill;
- (iii) ~~furnished~~Furnished as an incidental, although integral, part of a physician's professional services; or
- (iv) 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.

(D) **Visiting nurse services.** Visiting nurse services are covered if:

- (i) ~~the~~The RHC is located in an area in which the Centers for Medicare and Medicaid Services (CMS) has determined there is a shortage of home health agencies;
- (ii) ~~the~~The services are rendered to members who are homebound;
- (iii) ~~the~~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~~The services are furnished under a written plan of treatment.

(E) **RHC encounter.** RHC "core" services (including preventive services, i.e., prenatal, EPSDT, or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and ~~an~~ an RHC health professional ~~(i.e., physicians, physician assistants, advanced practice nurses, certified nurse midwives, clinical psychologists and clinical social workers)~~ (physicians, PAs, APRNs, CNMs, CPs, and CSWs). 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. Payment is made for one (1) encounter per member per day. Medical review will be required for additional visits for children. Payment is also limited to four (4) visits per member per month for adults.

(F) **Off-site services.** RHC services provided off-site of the

clinic are covered as long as the RHC has a compensation arrangement with the RHC practitioner that SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The ~~rural health clinic~~RHC must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the ~~rural health clinic~~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.** ~~A Rural Health Clinic~~An RHC must provide other items and services which are not "RHC services" as described in ~~(a)~~(1) of this Section, and are separately billable ~~to the SoonerCare program~~within the scope of the SoonerCare fee-for-service (FFS) contract. Coverage of services are based upon the scope of coverage under the SoonerCare program.

(A) Other ambulatory services include, but are not limited to:

- (i) ~~dental~~Dental services for members under ~~age 21~~the age of twenty-one (21);
- (ii) ~~optometric~~Optometric services;
- (iii) ~~clinical~~Clinical lab tests performed in the RHC lab, including the lab tests required for RHC certification;
- (iv) ~~technical~~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~~Durable medical equipment;
- (vi) ~~emergency ambulance transportation~~Transportation by ambulance [refer to Oklahoma Administrative Code (OAC) 317:30-5-335];
- (vii) ~~prescribed~~Prescribed drugs;
- (viii) ~~prosthetic~~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~~Specialized laboratory services furnished away from the clinic;
- (x) ~~inpatient~~Inpatient services;
- (xi) ~~outpatient~~Outpatient hospital services; and
- (xii) Applied behavior analysis (ABA) [refer to OAC 317:30-3-65.12].
- (xiii) Diabetes self-management training (DSMT) (refer to OAC 317:30-5-1080 - 1084).

(B) Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist or optometric services by a licensed optometrist for members under ~~age 21~~the age of twenty-one (21). Encounters are billed as one (1) of the following:

- (i) **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.

(ii) **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.

(iii) **Visual analysis.** Visual analysis (initial or yearly) 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. Glasses must be billed separately. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(C) Services listed in ~~(a)(2)(A), (v)-(viii)~~, of this Section, furnished on-site, require separate provider agreements with the ~~OHCA~~Oklahoma Health Care Authority (OHCA). Service item ~~(a)(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.)

(D) 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.

317:30-5-357. Coverage for children

Coverage for rural health clinic (RHC) services and other ambulatory services for children include the same services as for adults in addition to the following:

(1) ~~The receipt of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) examination by a Medicaid eligible individual under age 21 renders that individual child eligible for all necessary follow-up care, whether or not the medically necessary services are covered under the Medicaid.~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are covered for eligible members under twenty-one (21) years of age in accordance with Oklahoma Administrative Code (OAC) 317:30-3-65. An EPSDT exam performed by an RHC must be billed on the appropriate claim form with the appropriate Preventative Medicinepreventive medicine procedure code from the Current Procedural Terminology Manual (CPT) manual. If an EPSDT screening is billed, an RHC encounter should not be billed on the same day. Refer to OAC 317:30-3-47 through 317:30-3-54 for coverages under EPSDT). Refer to OAC 317:30-3-65 through 317:30-3-65.12.

(2) Under EPSDT, coverage is allowed for visual screenings and eyeglasses to correct visual defects. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(3) An EPSDT screening is considered a comprehensive examination. A provider billing the Medicaid program for an EPSDT ~~screen~~screening may not bill any other visits for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. Additional services such as tests, immunizations, etc., required at the time of screening may be billed independently from the screening.

(4) The administration fee for immunizations should be billed if provided at the same time as a scheduled EPSDT examination.

(5) Payment may be made directly to the RHC for the professional services of physician assistants performing EPSDT screenings within the certified RHC. The claim form must include the signature of the supervising physician.

PART 37. ADVANCED PRACTICE REGISTERED NURSE

317:30-5-376. Coverage by category

Payment is made to ~~Advanced Practice Nurse~~advanced practice registered nurses (APRNs) as set forth in this Section.

(1) **Adults.** Payment for adults is made for primary care health services, within the scope of practice of ~~Advanced Practice Nurse~~an APRN and within the scope of the Oklahoma Health Care Authority (OHCA) medical programs.

(2) **Children.** Payment for children is made for primary care health services, within the scope of practice of ~~Advanced Practice Nurse~~an APRN, to ~~children and adolescents under 21~~members under twenty-one (21) years of age, including ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening services and within the scope of the Oklahoma Health Care Authority medical programs.

(A) Payment is made to eligible providers for ~~Early and Periodic Screening, Diagnosis and Treatment of individuals under age 21~~EPSDT services to members under twenty-one (21) years of age. Specific guidelines for the EPSDT program including the periodicity schedule are found in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-65 through ~~317:30-3-65.11~~317:30-3-65.12.

(B) Comprehensive screening examinations are to be performed by a provider qualified under State law to furnish primary health care services.

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

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.1. Provision of other health services outside of the Health Center core services

(a) If the Center chooses to provide other ~~SoonerCare~~Oklahoma Medicaid State Plan covered health services which are not included in the Health Center core service definition in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment, and billing procedures described by the ~~OHCA~~Oklahoma Health Care Authority (OHCA), and these services (e.g., home health services) are not included in the PPS settlement methodology in OAC 317:30-5-664.12.

(b) Other medically necessary health services that will be reimbursed at the fee-for-service (FFS) rate include, but are not limited to:

- (1) ~~dental~~Dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;
- (2) ~~eyeglasses~~ (OAC ~~317:30-5-430~~ and OAC ~~317:30-5-450~~)Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);
- (3) ~~clinical~~Clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);
- (4) ~~technical~~Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);
- (5) ~~durable~~Durable medical equipment (refer to OAC 317:30-5-210);
- (6) ~~emergency ambulance transportation~~Transportation by ambulance (refer to OAC 317:30-5-335);
- (7) ~~prescribed~~Prescribed drugs (refer to OAC 317:30-5-70);
- (8) ~~prosthetic~~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;
- (9) ~~specialized~~Specialized laboratory services furnished away from the clinic;
- (10) ~~Psychosocial Rehabilitation Services~~rehabilitation services [refer to OAC ~~317:30-5-241.3~~] (refer to OAC 317:30-5-241.3); ~~and~~
- (11) ~~behavioral~~Behavioral health related case management services (refer to OAC 317:30-5-241.6); ~~and~~
- (12) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12).
- (13) Diabetes self-management training (DSMT) (refer to OAC 317:30-5-1080 through 317:30-5-1084).

PART 108. NUTRITION SERVICES

317:30-5-1076. Coverage by category

Payment is made for ~~Nutritional Services~~nutritional services as

set forth in this ~~section~~Section.

(1) **Adults.** Payment is made for six (6) hours of medically necessary nutritional counseling per year by a licensed registered dietitian. All services must be prescribed by a physician, physician assistant (PA), advanced practice registered nurse (APRN), or certified nurse midwife (CNW), and be ~~face-to-face~~face-to-face encounters between a licensed registered dietitian and the member. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness. Nutritional services for the treatment of obesity is not covered unless there is documentation that the obesity is a contributing factor in another illness.

(2) **Children.** Payment is made for medically necessary nutritional counseling as described above for adults. Nutritional services for the treatment of obesity may be covered for children as part of the ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Additional services which are deemed medically necessary and allowable under federal regulations may be covered by the EPSDT benefit found at OAC 317:30-3-65 ~~and through 317:30-3-65.11~~317:30-3-65.12.

(3) ~~Home and Community Based Waiver Services~~community-based services (HCBS) waiver for the Intellectually Disabled~~intellectually disabled~~. All providers participating in the ~~Home and Community Based Waiver Services~~HCBS waiver for the intellectually disabled program must have a separate contract with ~~OHCA~~the Oklahoma Health Care Authority (OHCA) to provide ~~Nutrition Services~~nutrition services under this program. All services are specified in the individual's plan of care.

(4) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Services which are not covered under Medicare should be billed directly to OHCA.

(5) **Obstetrical patients.** Payment is made for a maximum of six (6) hours of medically necessary nutritional counseling per year by a licensed registered dietitian for members at risk for or those who have been recently diagnosed with gestational diabetes. The initial consultation may be in a group setting for a maximum of two (2) hours of class time. Thereafter, four (4) hours of nutritional counseling by a licensed registered dietitian may be provided to the individual if deemed medically necessary, which may include a post-partum visit, typically done at ~~six~~(6) weeks after delivery. All services must be prescribed by a physician, ~~physician assistant, advanced practice nurse or a certified nurse midwife~~PA, APRN, or CNM and be ~~face-to-face~~face to face between a licensed registered dietitian and the member(s). Services must be solely for the prevention, diagnosis, or treatment of gestational diabetes.

PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND

URBAN INDIAN CLINICS (I/T/Us)

317:30-5-1090. Provision of other health services outside of the I/T/U encounter

(a) Medically necessary SoonerCare covered services that are not included in the I/T/U outpatient encounter rate may be billed outside the encounter rate within the scope of the SoonerCare fee-for-service (FFS) contract. The services will be reimbursed at the ~~fee-for-service~~FFS rate, and will be subject to any limitations, restrictions, or prior authorization requirements. Examples of these services include, but are not limited to:

- (1) ~~durable~~Durable medical equipment [refer to Oklahoma Administrative Code (OAC) 317:30-5-210];
- (2) ~~glasses~~Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);
- (3) ~~ambulance~~Transportation by ambulance (refer to OAC 317:30-5-335);
- (4) ~~home~~Home health [refer to OAC 317:30-5-546] (refer to OAC 317:30-5-546);
- (5) ~~inpatient~~Inpatient practitioner services (refer to OAC 317:30-5-1100);
- (6) ~~non-emergency~~Non-emergency transportation [refer to OAC 317:35-3-2] (refer to OAC 317:35-3-2);
- (7) ~~behavioral~~Behavioral health case management [refer to OAC 317:30-5-241.6] (refer to OAC 317:30-5-241.6);
- (8) ~~psychosocial~~Psychosocial rehabilitative services [refer to OAC 317:30-5-241.3] (refer to OAC 317:30-5-241.3); and
- (9) ~~psychiatric~~Psychiatric residential treatment facility services [refer to OAC 317:30-5, Part 6, Inpatient Psychiatric Hospitals]. (refer to OAC 317:30-5-95 through 317:30-5-97);
- (10) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12); and
- (11) Diabetes self-management training (DSMT) (refer to OAC 317:30-5-1080 through 317:30-5-1084).

(b) If the I/T/U facility chooses to provide other ~~SoonerCare~~Oklahoma Medicaid State Plan covered health services which are not included in the I/T/U encounter definition, those service providers must be contracted with ~~OHCA~~the Oklahoma Health Care Authority (OHCA) and bill for those services under their assigned provider number consistent with program coverage limitations and billing procedures described by the OHCA.

(c) Providers may bill for antepartum and postpartum visits, and a cesarean or vaginal delivery as individual encounters, or a provider can bill the packaged/bundled rate for total obstetrical care (OB) (which includes antepartum/postpartum visits and delivery). Providers may not bill for both antepartum/postpartum visits and a packaged/bundled rate for total OB care for the same episode of care. Refer to OAC 317:30-5-22 for more detailed obstetrical care policy.

PART 112. PUBLIC HEALTH CLINIC SERVICES

317:30-5-1154. CHD/CCHD County health department (CHD) and city-county health department (CCHD) services/limitations

CHD/CCHD service limitations are:

- (1) ~~Child Guidance~~ guidance services ~~(see OAC 317:30-3-65 through OAC 317:30-3-5-65.11 for specifics regarding program requirements)~~. (refer to Oklahoma Administrative Code (OAC) 317:30-5-1023).
- (2) Dental services ~~[OAC 317:30-3-65.4(7)]~~. (refer to OAC 317:30-3-65.4(7) for specific coverage).
- (3) Early and Periodic Screening, ~~Diagnosis,~~ Diagnostic and Treatment (EPSDT) services ~~(including blood lead testing and follow-up services)~~, including blood lead testing and follow-up services ~~(see refer to OAC 317:30-3-65 through OAC 30-3-65.11)~~ 317:30-3-65.12 for specific coverage).
- (4) Environmental investigations.
- (5) Family ~~Planning~~ planning and SoonerPlan Family ~~Planning~~ family planning services ~~(see refer to OAC 317:30-5-12 for specific coverage guidelines)~~.
- (6) Immunizations (adult and child).
- (7) Blood lead testing ~~(see refer to OAC 317:30-3-65.4 for specific coverage)~~.
- (8) Newborn hearing screening.
- (9) Newborn metabolic screening.
- (10) Maternity services ~~(see refer to OAC 317:30-5-22 for specific coverage)~~.
- (11) Public health nursing services.
- (12) Tuberculosis case management and directly observed therapy.
- (13) Laboratory services.
- (14) Targeted case management.