Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to the Oklahoma Health Care Authority (OHCA) Proposed Changes Blog.

OHCA COMMENT DUE DATE: February 17, 2017

The proposed policy was submitted to the Medical Advisory Committee on November 17, 2016 as an emergency policy change. The proposed policy was presented for Tribal Consultation on November 1, 2016. The proposed Permanent Rule is scheduled to be presented to the Medical Advisory Committee on March 9, 2017 and the OHCA Board of Directors on March 23, 2017.
Reference: APA WF 16-18

SUMMARY:
Telemedicine Revisions – The proposed telemedicine revisions replace telemedicine with telehealth, define telehealth, remove language requiring informed consent, and update text to mirror current practice.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 36 O.S. Sections 6801 - 6804; [OK H.B. No. 2547]

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: Harvey Reynolds
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 16-18

A. Brief description of the purpose of the rule:

The proposed revisions amend language in Chapter 30 to reflect the repeal of 36 O.S. Section 6804, of The Oklahoma

Telemedicine Act. The repeal of Section 6804 eliminates the informed consent requirements from Oklahoma Statutes.
The aforementioned changes were approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed:
The proposed telemedicine revisions to replace telemedicine with telehealth allow the flexibility for use of telehealth technologies that could potentially be used to deliver healthcare services to SoonerCare members. The new proposed revisions also define telehealth and specific telehealth technologies. In addition, revisions update text to mirror current practice.

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:

Providers using telehealth technology to deliver compensable SoonerCare services will be affected by the proposed rule. This rule should not place any cost burden on private or public entities. No information on any cost impacts were received from any entity.

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

SoonerCare members will benefit from the proposed rule through enhanced access to care as more healthcare services are delivered using telehealth. In addition, SoonerCare providers will benefit through enhanced modes of delivery of the healthcare services they provide.

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:

The proposed rule may have a positive economic benefit on providers who deliver healthcare services by telehealth.

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

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anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

Budget Impact: Agency staff has determined that the previously approved Emergency rule and the proposed Permanent rule will most likely be budget neutral over time as the delivery of healthcare services shifts from in-person to telehealth.

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:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

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 agency does not anticipate that the proposed rule will have an adverse effect on small businesses.

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 are no other legal methods to achieve the purpose of the proposed rule. Measures included a formal public comment period and tribal consultation.

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 may have a positive effect on public health as the rule reflects more inclusiveness of telehealth delivery of healthcare services.

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

The agency does not anticipate any detrimental effect on the public health, safety or environment if the proposed rule is not implemented.

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

Prepared date: October 28, 2016

RULE TEXT:

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

SUBCHAPTER 3. GENERAL PROVIDER SERVICES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-27. ~~Telemedicine~~Telehealth

(a) **Definitions.** The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise.

"Remote patient monitoring" means the use of digital technologies to collect medical and other forms of health data (e.g. vital signs, weight, blood pressure, blood sugar) from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.

"Store and forward" means the acquisition (storing) of clinical information (e.g. data, document, image, sound, video) that is then electronically transmitted (forwarded to or retrieved by) to another site for clinical evaluation.

"Telehealth" means the mode of delivering healthcare services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of patients, at a distance from health care providers.

~~(a)~~(b) **Applicability and scope.** The purpose of this Section is to implement ~~telemedicine~~telehealth policy that improves access to health care services, while complying with all applicable ~~federal~~Federal and ~~state~~State ~~statutes~~laws and regulations. ~~Telemedicine~~Telehealth services are not an expansion of SoonerCare covered services but an option for the delivery of

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certain covered services. However, if there are technological difficulties in performing an objective thorough medical assessment or problems in the member's understanding of ~~telemedicine~~telehealth, hands-on-assessment and/or in person care must be provided for the member. Any service delivered using telehealth technology must be appropriate for ~~telemedicine~~telehealth delivery and be of the same quality and otherwise on par with the same service delivered in person. A ~~telemedicine~~telehealth encounter must comply with the Health Information Portability and Accountability Act (HIPAA). For purposes of SoonerCare reimbursement ~~telemedicine~~telehealth is the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment that occur in real-time and when the member is actively participating during the transmission. ~~Telemedicine~~Telehealth does not include the use of audio only telephone, electronic mail~~,~~ or facsimile transmission.~~ Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. Asynchronous or "store and forward" applications would not be considered telemedicine but may be utilized to deliver services.~~

~~(b)~~(c) **Conditions.** The following conditions apply to all services rendered via ~~telemedicine~~telehealth.

(1) Interactive audio and video telecommunications must be used, permitting encrypted real-time communication between the physician or practitioner and the SoonerCare member. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the ~~telemedicine~~telehealth information transmitted. As a condition of payment the member must actively participate in the ~~telemedicine~~telehealth visit.

(2) The ~~telemedicine~~telehealth equipment and transmission speed and image must be technically sufficient to support the service billed. If a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality for decision making. Staff involved in the ~~telemedicine~~telehealth visit need to be trained in the use of the ~~telemedicine~~telehealth equipment and competent in its operation.

(3) The medical or behavioral health related service must be provided at an appropriate site for the delivery of ~~telemedicine~~telehealth services. An appropriate ~~telemedicine~~ telehealth site is one that has the proper security measures in place; the appropriate administrative, physical and technical safeguards should be in place that ~~ensure~~ensures the confidentiality, integrity~~,~~ and security of electronic

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protected health information. The location of the room for the encounter at both ends should ensure comfort, privacy~~,~~ and confidentiality. Both visual and audio privacy are important, placement and selection of the rooms should consider this. Appropriate ~~telemedicine~~telehealth equipment and networks must be used considering factors such as appropriate screen size, resolution~~,~~ and security. Providers and/or members may provide or receive ~~telemedicine~~telehealth services outside of Oklahoma when medically necessary.

(4) The provider must be contracted with SoonerCare and appropriately licensed for the service to be provided. If the provider is outside of Oklahoma, the provider must comply with all laws and regulations of the provider's location, including health care and ~~telemedicine~~telehealth requirements.

~~(5) The health care practitioner must obtain written consent from the SoonerCare member that states he or she agrees to participate in the telemedicine-based office visit. The consent form must include a description of the risks, benefits and consequences of telemedicine and be included in the member's medical record.~~

~~(6)~~(5) If the member is a minor child, a parent/guardian must present the minor child for ~~telemedicine~~telehealth services unless otherwise exempted by State or Federal law. The parent/guardian need not attend the ~~telemedicine~~telehealth session unless attendance is therapeutically appropriate.

~~(7)~~(6) The member retains the right to withdraw at any time.

~~(8)~~(7) All ~~telemedicine~~telehealth activities must comply with the HIPAA Security Standards, OHCA policy, and all other applicable ~~state~~State and ~~federal~~Federal laws and regulations.

~~(9)~~(8) The member has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.

~~(10)~~(9) There will be no dissemination of any member images or information to other entities without written consent from the member.

~~(c)~~(d) **Reimbursement.**

(1) Health care services delivered by telehealth such as Remote Patient Monitoring, Store and Forward, or any other telehealth technology, must be compensable by OHCA in order to be reimbursed.

~~(1)~~(2) Services provided by ~~telemedicine~~telehealth must be billed with the appropriate modifier.

~~(2)~~(3) If the technical component of an X-ray, ultrasound or electrocardiogram is performed during a ~~telemedicine~~ telehealth transmission, the technical component can be

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billed by the provider that provided that service. The professional component of the procedure and the appropriate visit code should be billed by the provider that rendered that service.
~~(3)~~(4) The cost of ~~telemedicine~~telehealth equipment and transmission is not reimbursable by SoonerCare.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) laboratory services;
(B) prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;
(C) technical component on radiology services;
(D) transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;
(E) pre-admission diagnostic testing performed within 72 hours of admission; and
(F) organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible members of the Oklahoma SoonerCare program, when treated in out-of-

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state hospitals will be reimbursed in the same manner as in-state hospitals.

(5) Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

(6) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.

(7) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

(8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.

(9) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

~~(10) When services are delivered via telemedicine to hospital inpatients, the originating site facility fee will be paid outside the DRG payment.~~

~~(11)~~(10) All inpatient services are reimbursed per the methodology described in this section and/or as approved under the Oklahoma State Medicaid Plan.

PART 35. RURAL HEALTH CLINICS

317:30-5-361. Billing

(a) **Encounters.** Payment is made for one encounter per member per day. Medical review will be required for additional visits for children. Payment is also limited to four visits per member per month for adults. Rural health clinics 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 HCPC 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

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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 Current Procedural Terminology Manual (CPT).

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

(7) **Visual analysis.** Optometric services for children are billed using the appropriate revenue code and a HCPCS code.

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

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

(2) **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.

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

(4) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required. The following are examples:

(A) DepoProvera 150 mg. (Medroxyprogesterone Acetate).

(B) Insertion and implantation of a subdermal contraceptive device.

(C) Removal, implantable contraceptive devices.

(D) Removal, with reinsertion, implantable contraceptive device.

(E) Insertion of intrauterine device (IUD).

(F) Removal of intrauterine device.

(G) ParaGard IUD.

(H) Progestasert IUD.

(5) **~~Glasses~~Eyeglasses.** ~~Glasses~~Eyeglasses prescribed by a

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licensed optometrist are billed using the appropriate revenue code and HCPCS code. Payment is limited to two ~~glasses~~eyeglasses per year. Any ~~glasses~~eyeglasses beyond this limit must be prior authorized and determined to be medically necessary.
~~(6) **Telemedicine.** The originating site facility fee for telemedicine services is not a rural health clinic service. When a rural health clinic serves as the originating site, the originating site facility fee is paid separately from the clinic's all-inclusive rate.~~

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.10. Health Center reimbursement

(a) In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, reimbursement is provided for core services and other health services at a Health Center facility-specific Prospective Payment System (PPS) rate per visit (encounter) determined according to the methodology described in OAC 317:30-5-664.12.
(b) As claims/encounters are filed, reimbursement for SoonerCare Choice members is made for all medically necessary covered primary care and other approved health services at the PPS rate.
~~(c) The originating site facility fee for telemedicine services is not a Federally Qualified Health Center (FQHC) service. When a FQHC serves as the originating site, the originating site facility fee is paid separately from the center's all-inclusive rate. Refer to OAC 317:30-3-27 for other specific coverage and exclusion requirements.~~
~~(d)~~(c) Primary and preventive behavioral health services rendered by health care professionals authorized in the FQHC approved state plan pages will be reimbursed at the PPS encounter rate.
~~(e)~~(d) Vision services provided by Optometrists within the scope of their licensure for non-dual eligible members and allowed under the Medicaid State Plan are reimbursed pursuant to the SoonerCare fee-for-service fee schedule.

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