Appendix A - SoonerSelect Medical Program Covered Services

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Service	Children (under 21 years of age)	Adults (21 years old and older)
Advanced Practice Registered Nurse (APRN)	Covered	Covered; four outpatient visits per month Alternative Benefit Plan (ABP): Four outpatient visits per month limit can be exceeded based on medical necessity
Allergy Testing	Covered	Covered; limited to 60 tests over three years ABP: Limit can be exceeded based on medical necessity
Alternative Treatment for Pain Management	Covered	Physical Therapy when provided in a non-hospital-based setting; initial evaluation is covered without prior authorization; twelve hours per year requires prior authorization Chiropractic Services: initial evaluation is covered without prior authorization; twelve visits per year requires prior authorization Limits can be exceeded based on medical necessity
Ambulance or Emergency Transportation	Covered	Covered
Ambulatory Surgical Center	Covered	Covered; Reimbursement outlined in Oklahoma Medicaid State Plan
Bariatric Surgery	Covered; upon meeting presurgical evaluation and weight loss requirements Prior authorization required	Covered upon meeting presurgical evaluation and weight loss requirements Not covered for the treatment of obesity alone Prior authorization required
Certified Registered Nurse Anesthetist and Anesthesiologist Assistants	Covered	Covered
Chemotherapy	Covered	Covered
Clinic Services	Covered Some services may require prior authorization	Covered Some services may require prior authorization
Diabetes Education	Covered; 10 hours per first year; two hours per subsequent year Limits can be exceeded based on medical necessity and under Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Covered; 10 hours per first year; two hours per subsequent year ABP: Limit can be exceeded based on medical necessity
Diagnostic Testing Entities	Covered Some services may require prior authorization	Covered Some services may require prior authorization
Donor Human Breast Milk	Covered during the first year of life Some services may require prior authorization	Not Covered
Durable Medical Equipment Supplies and Appliances	Covered Requires prescription by a medical provider May require prior authorization	Covered Requires prescription by a medical provider May require prior authorization
EPSDT and early intervention services, including health and immunization history; COVID-19 vaccine counseling; physical exams, various health assessments and counseling; lab and screening tests; and necessary follow-up care	Covered Some services may require prior authorization	Not Covered
Emergency Department	Covered	Covered
Eye Care to Treat a Medical or Surgical Condition	Covered	Covered
Family Planning Services	Covered	Covered
Federally Qualified Health Center and Rural Health Clinic Services	Covered	Covered
Genetic Counseling and Testing	Covered for pregnant Health Plan Enrollees and Health Plan Enrollees meeting medical necessity criteria May require prior authorization	Covered for pregnant Health Plan Enrollees and Health Plan Enrollees meeting medical necessity criteria May require prior authorization
Hearing Services	Covered May require prior authorization	Not Covered
Home Health Care Services	Covered	Covered
Hospice Care	Covered for Health Plan Enrollees with a life expectancy of six months or less	Not Covered ABP: Covered for Health Plan Enrollees with a life expectancy of six months or less
Immunizations, as recommended by the Advisory Committee of Immunization Practices	Covered	Covered
Infusion Therapy	Covered	Covered when Medically Necessary and not considered a compensable part of the procedure.
Inpatient Hospital Services	Covered	Covered • Inpatient hospital service (inpatient stay): No limit • Inpatient physician services: Covered • Inpatient surgical services: No limit • Inpatient rehab hospital services: 90 days per individual per State Fiscal Year (SFY) ABP limits: • Inpatient hospital service (inpatient stay): No limit • Inpatient physician services: Covered • Inpatient surgical services: No limit • Inpatient rehab hospital services: 90 days per individual per SFY Amount limits can be exceeded based on medical necessity
Laboratory, X-ray, Diagnostic Imaging, Imaging (CT/PET scans, MRIs)	Covered May require prior authorization	Covered May require prior authorization
Lactation Consultant	Covered for pregnant and postpartum Health Plan Enrollees	Covered for pregnant and postpartum Health Plan Enrollees
Lodging and Meals for the Health Plan Enrollee and/or One Approved Medical Escort	Covered if prior approved	Covered if prior approved
Long-term Care Hospital for Children	Covered	Not Covered
Mammograms	Covered	Covered

Service	Children (under 21 years of age)	Adults (21 years old and older)
Maternal and Infant Licensed Clinical Social Worker (LCSW) services	Covered for pregnant and postpartum Health Plan Enrollees	Covered for pregnant and postpartum Health Plan Enrollees
Non-Emergency Medical Transportation (NEMT)	Covered	Covered
Nurse Midwives	Covered under EPSDT	Covered
Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Services	Covered by Contractor for up to 60 days pending the level of care determination	Covered by Contractor for up to 60 days pending the level of care determination
Nutrition Services (dietician)	Covered	Covered; up to six hours per year Nutritional services for treatment of obesity are not covered. Services must be expressly for diagnosing, treating or preventing, or minimizing effects of illness. ABP: Limits can be exceeded based on medical necessity
Orthotics	Covered	Not Covered ABP: Covered without limitations when Medically Necessary
Outpatient Hospital and Surgery Services	Covered	Covered
Parenteral/Enteral Nutrition	Covered May require prior authorization	Covered May require prior authorization
Personal Care	Covered	Covered
Physician and Physician Assistant Services	Covered	Covered; four outpatient visits per month ABP: Four outpatient visits per month limit can be exceeded based on medical necessity
Podiatry	Covered	Covered
Post-stabilization Care Services	Covered	Covered
Pregnancy and Maternity Services, including Prenatal, Delivery, and Postpartum	Covered	Covered
Prescription Drugs	Covered	Covered; up to six prescriptions per month, including up to two brand name drugs without prior authorization and up to three brand name drugs with prior authorization (within the six prescription limit)
Preventive Care and Screening	Refer to EPSDT coverage	Covered as outlined in the State Plan pages for Outpatient Hospital Services, other laboratory and x-ray services, Diagnosis and Treatment of Conditions Found, Clinic Services, Screening Services, and Rehabilitative Services. There is not a standalone preventive services benefit package for adults providing coverage for services identified with an A or B rating by the US Preventive Services Task Force (USPSTF).
Private Duty Nursing	Covered up to 16 hours per day; with exceptions made to the 16 hour limit made for up to 30 days immediately following hospitalization or the temporary incapacitation of the primary caregiver	Not Covered ABP limit: This service is substituted with skilled nursing under the home health services benefit.
Prosthetic Devices	Covered when prior authorized	Limited coverage with required prior authorization; only breast prosthesis and support accessories and prosthetic devices inserted during surgery are covered ABP: Covered without limitations when Medically Necessary
Public Health Clinic Services	Covered	Covered; four visits per month ABP: Four visits per month limit can be exceeded based on medical necessity
Radiation	Covered	Covered
Reconstructive Surgery	Covered May require prior authorization	Covered: Non-cosmetic; breast reconstruction/implantation/removal is covered only when it is a direct result of a mastectomy which is Medically Necessary May require prior authorization
Renal Dialysis Facility Services	Covered	Covered
Routine Patient Cost in Qualifying Clinical Trials	Covered to the extent that the provision of the service would otherwise be covered outside of the participation in the clinical trial, is a covered State Plan / 1115 waiver service, and meets the requirements in OAC 317:30-3-57.1	Covered to the extent that the provision of the service would otherwise be covered outside of the participation in the clinical trial, is a covered State Plan / 1115 waiver service, and meets the requirements in OAC 317:30-3-57.1
School-based Health Related Services	Covered	Not Covered
Telehealth	Covered	Covered
Therapy services — Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)	OT and PT — initial evaluation covered without prior authorization; treatment requires prior authorization ST — evaluation and treatment require prior authorization	Rehabilitative Services: 15 visits per year for each OT, PT, & ST (cumulative total: 45 visits) ABP Limit: Habilitative Services: 15 visits per year for each OT, PT, & ST (cumulative total: 45 visits) Rehabilitative Services: 15 visits per year for each OT, PT, & ST (cumulative total: 45 visits)
Tobacco Cessation Products	Nicotine replacement therapy (NRT) products (including patches, gum, lozenges, inhalers, and nasal spray) and Zyban®/Bupropion to include combination therapy of these products are covered. Chantix®/Varenicline is covered up to 180 Days per 12 months. Tobacco cessation products are covered without duration limits, prior authorization, or Co-payment and do not count against monthly prescription limits. Limited to 8 tobacco cessation counseling sessions (99406 - 99407) with contracted providers per year.	Nicotine replacement therapy (NRT) products (including patches, gum, lozenges, inhalers, and nasal spray) and Zyban®/Bupropion to include combination therapy of these products are covered. Chantix®/Varenicline is covered up to 180 Days per 12 months. Tobacco cessation products are covered without duration limits, prior authorization, or Co-payment and do not count against monthly prescription limits. Limited to 8 tobacco cessation counseling sessions (99406 - 99407) with contracted providers per year.
Transplant Services	Covered when prior authorized Cornea and kidney transplants do not require prior authorization	Covered when prior authorized Cornea and kidney transplants do not require prior authorization
Urgent Care Centers or Facilities	Covered	Covered; up to four outpatient visits per month ABP: Four outpatient visits per month limit can be exceeded based on Medical Necessity
Vision Services	Covered under EPSDT; with a limit of two eyeglass frames per year	Coverage to treat a medical or surgical condition only; no coverage for routine eye exams

Service	Children (under 21 years of age)	Adults (21 years old and older)
Applied Behavioral Analysis	Covered when prior authorized	Not Covered
Certified Community Behavioral Health (CCBH) Services	Covered	Covered
Day Treatment Services	Covered when prior authorized for a minimum of three hours per day for four days per week	Not Covered
Inpatient Hospital — Freestanding Psychiatric	Covered when prior authorized	Ages 21–64: Covered when prior authorized in accordance with 1115 IMD waiver for a maximum of 60 days per episode Ages 65 and older: Covered when prior authorized
Inpatient Hospital — General Acute	Covered when prior authorized	Covered when prior authorized
Licensed Behavioral Health Provider (who can bill independently)	Covered when prior authorized	Not Covered
Medication Assisted Treatment (Suboxone® [buprenorphine/ naloxone SL films], Vivitrol, Methadone)	Covered	Covered
Opioid Treatment Programs	Covered when prior authorized	Covered when prior authorized
Outpatient Behavioral Health Agency Services	Covered when prior authorized	Covered when prior authorized
Partial Hospitalization	Covered when prior authorized for a minimum of three hours per day for five days per week	Covered when prior authorized for a minimum of three hours per day for five days per week
Peer Recovery Support Services	Covered for ages 16 through 21 when prior authorized	Covered when prior authorized
Program of Assertive Community Treatment (PACT) Services	Covered for ages 18 through 21	Covered
Psychiatric Residential Treatment Facility	Covered when prior authorized	Not Covered
Psychiatrist	Covered	Covered
Psychologist (who can bill independently)	Covered when prior authorized	Covered when prior authorized
Substance Abuse Treatment	Outpatient substance abuse treatment covered Residential substance abuse covered in accordance with the Title XIX State Plan and accordance with 1115 IMD waiver	Outpatient substance abuse treatment covered Residential substance abuse covered in accordance with the Title XIX State Plan and accordance with 1115 IMD waiver
Targeted Case Management	Covered for targeted populations when prior authorized	Covered for targeted populations when prior authorized
Therapeutic Behavioral Services, Family Support, and Training	Covered for children with serious emotional disturbance in a systems of care wraparound team	Not Covered
Therapeutic Foster Care	Covered when prior authorized	Not Covered