DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid & Children's Health, Region VI

May 5, 2010

Our Reference: SPA-OK-10-03

Dr. Lynn Mitchell, State Medicaid Director
Oklahoma Health Care Authority
4545 North Lincoln Blvd., Suite 124
Oklahoma City, Oklahoma 73105

Dear Dr. Mitchell:

We have reviewed the proposed amendment to your Medicaid State Plan submitted under Transmittal Number 10-03. This state plan amendment eliminates payment for three surgical errors known as "never events," eliminates payment for certain hospital acquired conditions identified as non-payable by Medicare and adds Anesthesiologist Assistants as compensable provider types effective on or after Febrary1, 2010.

In the future, when the State submits a State Plan Amendment (SPA) that may impact Indians or Indian health providers, CMS will look for evidence of the State's tribal consultation process for that SPA. Pursuant to section 1902 (a) (73) of the Act added by section 5006 (e) of the Recovery and Reinvestment Act of 2009, the State must submit evidence to CMS regarding the solicitation of advice prior to submission of the SPA. This consultation must include all federally recognized tribes, Indian Health Service and Urban Indian Organizations within the state.

Transmittal Number 10-03 is approved with an effective date of February 1, 2010 as requested. A copy of the HCFA-179, Transmittal No. 10-03 dated February 2, 2010 is enclosed along with the approved plan pages.

If you have any questions, please contact Scott Harper at (214) 767-6564.

Sincerely

[redacted]

Bill Brooks
Associate Regional Administrator
Division of Medicaid and Children's Health

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 10-03

2. STATE: Oklahoma

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
February 1, 2010

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS A NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.10, 42 CFR 440.20, 42 CFR 440.50, 42 CFR 440.60, 42 CFR 440.166

7. FEDERAL BUDGET IMPACT
a. FFY 2010 $0
b. FFY 2011 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Refer to Attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Refer to Attachment

10. SUBJECT OF AMENDMENT
Eliminate payment for 3 surgical errors known as "never events", eliminate payment for certain hospital acquired conditions identified as non-payable by Medicare, and add Anesthesiologist Assistants as compensable provider types.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor does not review State Plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mike Fogarty

14. TITLE
Chief Executive Officer

15. DATE SUBMITTED
February 4, 2010

16. RETURN TO
Oklahoma Health Care Authority
Attn: Cindy Roberts
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
4 Februray, 2010

18. DATE APPROVED
5 May, 2010

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
1 February, 2010

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Bill Brooks

22. TITLE
Associate Regional Administator
Division of Medicaid & Chidlren's Health

23. REMARKS
c: Mike Fogarty
Cindy Roberts
Tywanda Cox
Traylor Rains
Rodney Ikard

FORM CMS-179 (07/92)

ATTACHMENT TO SPA 10-03
Oklahoma Health Care Authority

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT
Attachment 3.1-A, Page 3a-1	Same Page, Revised 11-01-07, TN # 07-18
Attachment 4.19-A, Page 2	Same Page, Revised 10-01-05, TN # 05-06
Attachment 4.19-B, Page 1●	Same Page, Revised 10-01-05, TN # ~~05-07~~ 08-18
Attachment 4.19-B, Page 3	Same Page, Revised 01-01-04, TN # 03-20
Attachment 4.19-B, Page 20	Same Page, Revised 01-01-08, TN # 07-14
Attachment 4.19-B, Page 20a	Same Page, Issued 01-01-08, TN # 07-14
Attachment 4.19-B, Page 21	Same Page, Revised 07-01-04, TN # 04-03

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

6.d. Other Practitioners' Services

A. Psychological Services – See 4b. EPSDT

B. Certified Registered Nurse Anesthetists - Payment is made for inpatient and outpatient anesthesia services which are in the scope of the Medicaid Program and under the appropriate scope of practice allowed under State law for Certified Registered Nurse Anesthetists.

C. Anesthesiologist Assistants - Payment is made for inpatient and outpatient anesthesia services which are in the scope of the Medicaid Program and under the appropriate scope of practice allowed under State law for Anesthesiologist Assistants.

D. Physician Assistants – Payment is made for services provided by licensed Physician Assistants within the current practice guidelines for the State of Oklahoma.

E. Nutritional Services – Payment is made for up to six hours of nutritional counseling per year. All services must be prescribed by a physician, physician assistant, advanced practice nurse or nurse midwife and be face to face encounters between the State licensed dietitian and the client. Limitations on nutritional services are not applicable for EPSDT individuals. Services must be expressly for diagnosing, treating or preventing or minimizing the effects of illnesses. Nutritional services for the treatment of obesity are not covered unless there is documentation that the obesity is a contributing factor in another illness.

F. Health Education and counseling services for pregnant women – Payment is made for pregnancy related and postpartum health education and counseling services provided by practitioners licensed by the state in accordance with 42 CFR 440.060(a). Services are designed to provide educational information to the pregnant woman in caring for herself during pregnancy within existing standards of care. Services include genetic counseling by licensed genetic counselors, lactation consulting and counseling by state licensed nurses and state licensed dieticians who are also certified International Board Lactation Consultants, psychosocial support services by licensed clinical social workers, and prenatal care coordination and patient education by licensed practitioners.

STATE Oklahoma
DATE RECD 2-4-10
DATE APP'D 5-5-10
DATE EFF 2-1-10
HCFA 179 10-03

A

Revised 02-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES INPATIENT HOSPITAL SERVICES

II. GENERAL REIMBURSEMENT POLICY (continued)

F. 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 Medicaid recipients and the provider will not accept the payment rate established under Section V of this plan. Prior Authorization is required.

G. New providers entering the Medicaid program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG PPS payment method or the statewide median rate for per diem methods.

H. All hospitals which meet the criteria in Section VI of this plan will be eligible for graduate medical education payments.

I. All hospitals which meet the criteria in Section VIII of this plan will be eligible for a disproportionate share adjustment.

J. Effective for services provided on or after February 1, 2010, approved inpatient hospital rates will not be paid for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.

K. Effective for services provided on or after April 1, 2010, approved inpatient hospital rates will not be paid for Hospital Acquired Conditions (HACs) that are identified as non-payable by Medicare.

III. PAYMENT METHODOLOGY FOR FREESTANDING REHABILITATION, AND FREESTANDING PSYCHIATRIC HOSPITALS

Effective October 1, 2005, reimbursement to freestanding rehabilitation and psychiatric hospitals for inpatient hospital services is paid on a prospective per diem level of care payment system. There are two distinct payment components under this system. Total per diem reimbursement will equal the sum of:

Level of care operating per diem
+
Fixed capital per diem

A. Level of Care Operating Per Diem Rates

1. The level of care per diem rates are payments for allowable operating costs and movable capital costs as defined in HCFA publication 15-1 for Medicare cost reporting purposes and reported on the HCFA 2552. No return on equity is included in the per diem rate. There are eight levels of care. For each level of care category, the payment rate was established based on the statewide rate in effect on September 30, 2005, for providing services within that level of care.

STATE Oklahoma
DATE REC'D. 2-4-10
DATE APP'D 5-5-10
DATE EFF 2-1-10
HCFA 179 10-03

A

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

I. Outpatient Hospital Reimbursement

General

The agency's fee schedule rate was set as of December 1, 2008, and is effective for service provided on or after that date. All rates are published on the agency's website at okhca.org.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency's website. These provisions apply to all hospitals approved for participation in the Oklahoma SoonerCare program. In no case can reimbursement for outpatient hospital services exceed the upper payment limits as defined under 42 CFR 447.321. Laboratory services will not exceed maximum levels established by Medicare. Clinical diagnostic lab services (not laboratory services) do not exceed the maximum levels.

Effective for services provided on or after February 1, 2010, payment for outpatient services will not be made for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.

A. Emergency Room Services

1. Payment will be made based on Medicare APC groups for Type A and Type B Emergency Departments.

B. Outpatient Surgery

1. Payment will be made for certain outpatient surgical procedures provided in hospitals and ambulatory surgery centers based on the Medicare Ambulatory Surgery Center (ASC) facility services payment system. The surgical procedures are classified into payment groups based on Current Procedural Terminology (CPT). All procedures within the same payment group are paid at a single payment rate. For purposes of specifying the services covered by the facility rate, the OHCA hereby adopts and incorporates herein by reference the Medicare ASC procedures.

STATE Oklahoma DATE REC'D 2-4-10 DATE APPV'D 5-5-10 DATE EFF 2-1-10 HCFA 179 10-03	A

Revised 02-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

1. Payment for physicians' services (includes medical and remedial care and services)

Payment for physician's services, radiology services and services rendered by other practitioners under the scope of their practice under State law, are covered under the Agency fee schedule. The payment amount for each service paid for under the fee schedule is the product of a uniform relative value unit (RVU) for each service and a conversion factor (CF). The CF converts the relative values into payment amounts. The general formula for calculating the fee schedule can be expressed as:

RVU x CF = Rate

EPSDT screenings and eye exams by optometrists have been incorporated into the fee schedule.

The fee schedule is uniformly applied to public and private providers unless otherwise described in the plan. The fee schedules for the above listed services are maintained in the Agency database and posted to the Agency's website (www.okhca.org).

Effective for services provided on or after February 1, 2010, payment will not be made to physicians or other practitioners for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES OTHER TYPES OF CARE

Anesthesiologists

The agency's rates were set as of January 1, 2008, and are effective for services on or after that date. All rates are published on the agency's website. Effective January 1, 2008, the anesthesia procedure codes listed in the 2008 CPT Code Book (CPT Codes 00100 through 01966 and 01968 through 01999) are eligible for reimbursement based on a formula involving base units and time units multiplied by an initial conversion factor. The conversion factor is set at an amount not to exceed a maximum allowable of $31.50. The CPT Codes are subject to published clinical edits and will be updated concurrently with the annual publication of the American Medical Association's CPT Code Book (CPT® is a registered trademark of the American Medical Association).

Anesthesia CPT Code 01967 will be reimbursed at a maximum reimbursement amount of $425 for one unit of service regardless of the base and time units involved in the procedure.

Effective January 1, 2008, governmental and non governmental providers will be subject to the same payment methodology as described in this section of the State Plan.

Effective January 1, 2008, the base unit values for the anesthesia codes (CPT Codes 00100 through 01966 and 01968 through 01999) will be taken from the 2008 American Association of Anesthesiologist (ASA) Relative Value Guide. Additional units are not eligible to be added to the ASA base value for additional difficulty.

Anesthesia time means the time during which the anesthesia provider [physician, certified registered nurse anesthetist (CRNA) or anesthesiologist assistant (AA)] providing anesthesia is present (face to face) with the patient. It starts when the anesthesia provider begins to prepare the patient for induction of anesthesia in the operating room or equivalent area and ends when the anesthesia provider is no longer furnishing anesthesia services to the patient. The anesthesia time must be documented in the medical record with begin and end times noted.

Physicians, CRNAs and AAs should report a quantity of one (1) for each minute of anesthesia time. For example, if anesthesia time is thirty-seven (37) minutes, the quantity would be reported as 37. The program will convert the actual minutes reported to anesthesia time units. One anesthesia time unit is equivalent to 15 minutes of anesthesia time.

The following formula provides an example of how an anesthesiologist will be reimbursed:

If the ASA RVU (base) for an anesthesia procedure is 4.00 and the surgery lasts 90 minutes (time = 6 units) with a maximum allowable CF of $31.50 the reimbursement is calculated as follows:

(4b+6u) x $31.50 = $315.00

Time is reported in "units" where each unit is expressed in 15 minute increments and will be calculated as continued on Attachment 4.19-B, Page 20a.

continued on Attachment 4.19-B, Page 20a.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Anesthesiologists (continued)

Time (in Minutes)	Unit(s) Billed
1-15	1.0
16-30	2.0
31-45	3.0
46-60	4.0
61-75	5.0
76-90	6.0
91-105	7.0
106-120	8.0
Etc.	

STATE Oklahoma
DATE REC'D 2-4-10
DATE APPV'D 5-5-10
DATE EFF 2-1-10
HCFA 179 10-03
A

Effective January 1, 2008, Anesthesia Healthcare Common Procedure Coding System (HCPC) modifiers must be reported for each anesthesia service billed and will determine the rate of reimbursement to each provider for anesthesia services. The modifiers are as follows:

2008 Published HCPC Modifier	Description	Payment Rate
AA	Anesthesia services performed personally by Anesthesiologist.	100%
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	Current Flat Rate; no time units
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	50%
QX	CRNA or AA service: with medical direction by a physician	50%
QY	Anesthesiologist medically directs one CRNA or AA	50%
QZ	CRNA or AA services	80%

Certified Registered Nurse Anesthetists

Modifiers must be reported for each anesthesia service billed and will determine the rate of reimbursement to each provider for anesthesia services. Payment is made to Certified Registered Nurse Anesthetists at a rate of 80 percent of the allowable for physicians for anesthesia services without medical direction and at a rate of 50 percent of the allowable when medically directed.

Anesthesiologist Assistants

Modifiers must be reported for each anesthesia service billed and will determine the rate of reimbursement to each provider for anesthesia services. Payment is made to Anesthesiologist Assistants at a rate of 80 percent of the allowable for physicians for anesthesia services without medical direction and at a rate of 50 percent of the allowable when medically directed.

Effective January 1, 2008, governmental and non governmental providers will be subject to the same payment methodology as described in this section of the State Plan.

Effective for services provided on or after February 1, 2010, payment will not be made to anesthesiologists, CRNAs or AAs for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES OTHER TYPES OF CARE

Physician Assistants

Payment is made to physician assistants at 20 percent of the surgery allowable for physicians when service is assisting a surgeon at surgery.

All other services are reimbursed at 100 percent of the physician allowable.

Effective for services provided on or after February 1, 2010, payment will not be made to physician assistants for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.

STATE Oklahoma
DATE REC'D 2-4-10
DATE APPV'D 5-5-10
DATE EFF 2-1-10
HCFA 179 10-03

A

SUPERSEDES: TN- 04-03

Revised 02-01-10

TN# 10-03 Approval Date 5-5-10 Effective Date 2-1-10
Supersedes
TN# 04-03

Marks, Marsha L. (CMS/SC)

From: Marks, Marsha L. (CMS/SC)
Sent: Thursday, May 13, 2010 7:42 AM
To: CMS CMSO_508_SPA
Subject: Approval Pkg for OK 10-03
Attachments: Final Approval Pkg for 10-03.pdf

See Attached.

State: Oklahoma

Brief Description: The plan eliminates payment for three surgical errors knows as "never events'; eliminates payment for certain hospital acquired conditions identified as non-payable by Medicare and adds Anesthesiologist Assistant as compensable providers types. This does not have a direct impact on Indians, Indian health programs or Urban Indian organizations.

Approval Date: 5 May, 2010

Effective Date : February, 2010

Marsha Marks // Dept of Health & Human Services // Centers for Medicare & Medicaid Services // Dallas Regional Office // Division of Medicaid & Children's Health // Dallas Texas 75202 // 214-767-6280 // Fax 214-767-0322 // marsha.marks@cms.hhs.gov