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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 18-0026

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

November 26, 2018

Our Reference: SPA OK 18-0026

Becky Pasternik-Ikard
Chief Executive Officer
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma 73105

Dear Ms. Pasternik-Ikard:

Enclosed is a copy of approved Oklahoma State Plan Amendment (SPA) No. 18-0026, with an effective date of October 1, 2018. This amendment was submitted to apply a three percent (3%) increase to the fee-for-service fee schedule for the following services: vaccine administration, outpatient hospital, clinical laboratory, physician, physician assistants, home health, freestanding ambulatory surgery centers (ASC), dental, renal dialysis facilities, anesthesiologists, hospice, ambulance transportation providers, and eyeglasses.

This letter affirms that OK 18-0026 is approved effective October 1, 2018 as requested by the State.

We are enclosing the CMS-179 and the following amended plan pages:

- Attachment 4.19-B, Introduction, Page 1
- Attachment 4.19-B, Introduction, Page 2
- Attachment 4.19-B, Page 1
- Attachment 4.19-B, Page 1a
- Attachment 4.19-B, Page 1b
- Attachment 4.19-B, Page 2b
- Attachment 4.19-B, Page 3
- Attachment 4.19-B, Page 4
- Attachment 4.19-B, Page 4b
- Attachment 4.19-B, Page 5
- Attachment 4.19-B, Page 6
- Attachment 4.19-B, Page 10.1
- Attachment 4.19-B, Page 19
- Attachment 4.19-B, Page 20
- Attachment 4.19-B, Page 20a
- Attachment 4.19-B, Page 21
- Attachment 4.19-B, Page 28.4a
- Page 66(b)

If you have any questions regarding this matter you may contact Stacey Shuman at 214-767-6479, or by email at stacey.shuman@cms.hhs.gov.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator

CC: Billy Bob Farrell, DMCH Dallas
Stacey Shuman, DMCH Dallas
Tia Lyles, CMS Baltimore

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: 18-26

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: October 1, 2018

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
Section 1902(a)(30)(A) of the Social Security Act; 42 CFR Parts 440 and 447

7. FEDERAL BUDGET IMPACT
a. FFY 2019 $ 18,787,769
b. FFY 2020 $ 19,637,104

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Page 66(b)	Page 66(b); TN # 16-01
Attachment 4.19 B, Introduction, Page 1	Attachment 4.19 B, Introduction, Page 1, NEW
Attachment 4.19 B, Introduction, Page 2	Attachment 4.19 B, Introduction, Page 2, NEW
Attachment 4.19-B, Page 1	Attachment 4.19-B, Page 1; TN # 18-09
Attachment 4.19-B, Page 1a	Attachment 4.19-B, Page 1a; TN # 16-03
Attachment 4.19-B, Page 1b	Attachment 4.19-B, Page 1b; TN # 16-03
Attachment 4.19-B, Page 2b	Attachment 4.19-B, Page 2b; TN# 16-04
Attachment 4.19-B, Page 3	Attachment 4.19-B, Page 3; TN # 18-21
Attachment 4.19-B, Page 4	Attachment 4.19-B, Page 4; TN# 16-06
Attachment 4.19-B, Page 4b	Attachment 4.19-B, Page 4b; TN # 16-07
Attachment 4.19-B, Page 5	Attachment 4.19-B, Page 5; TN # 16-08
Attachment 4.19-B, Page 6	Attachment 4.19-B, Page 6; TN # 16-27
Attachment 4.19-B, Page 10.1	Attachment 4.19-B, Page 10.1; TN # 16-23
Attachment 4.19-B, Page 19	Attachment 4.19-B, Page 19; TN# 16-11
Attachment 4.19-B, Page 20	Attachment 4.19-B, Page 20; TN# 16-12
Attachment 4.19-B, Page 20a	Attachment 4.19-B, Page 20a; TN# 16-12
Attachment 4.19-B, Page 21	Attachment 4.19-B, Page 21; TN # 16-05
Attachment 4.19-B, Page 28.4a	Attachment 4.19-B, Page 28.4a; TN # 17-06

10. SUBJECT OF AMENDMENT
FFS fee schedule rates update to include a three (3) percent increase to reimbursement for the following services: vaccine administration, outpatient hospital, clinical laboratory, physician, physician assistants, home health, freestanding ASC, dental, renal dialysis facilities, anthesiologists, hospice, ambulance transportation providers, and eyeglasses.

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
Becky Pasternik-Ikard

14. TITLE
Chief Executive Officer

15. DATE SUBMITTED
September 14, 2018

16. RETURN TO
Oklahoma Health Care Authority
Attn: Tywanda Cox
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED
September 14, 2018	November 26, 2018

PLAN APPROVED - ONE C[redacted]	
19. EFFECTIVE DATE OF APPROVED MATERIAL October 1, 2018	20. S[redacted]
21. TYPED NAME Bill Brooks	22. TITLE Bill Brooks, ARA Division of Medicaid and Children's Health (DMCH)
23. REMARKS c: Becky Pasternik-Ikard Tywanda Cox	

FORM CMS-179 (07/92)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928 (c) (2) (C) (ii) of the Act

(i) A provider may impose a charge for the administration of a qualified vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

_X_ sets a payment rate at the level of the regional maximum established by the DHHS Secretary for public providers.
The rate for public providers is $19.58.

___ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

_X_ sets a payment rate below the level of the regional maximum established by the DHHS Secretary for non-public providers.
The rate for private providers is $19.58 minus the rate reductions that are in effect.

___ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The agency's fee schedule rate was set as of October 1, 2018 and is effective for services provided on or after that date. All rates are published on the agency's website at www.okhca.org/feeschedules. As indicated above, public providers are reimbursed at the level of the regional maximum.

Private providers are defined as providers that do not have an affiliation with a government agency.

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

"Other"-The State will attempt to set administration fee at Regional Maximum at earliest opportunity for non-public providers.

State: Oklahoma
Date Received: 14 September, 2018
Date Approved: 26 November, 2018
Effective Date: 1 October, 2018
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DATES FOR ESTABLISHING PAYMENT RATES FOR ATTACHMENT 4.19-B SERVICES

Effective Dates for Reimbursement Rates for Specified Services:

Reimbursement rates for the services listed on this introduction page are effective for services provided on or after that date with two exceptions:

1. Medicaid reimbursement using Medicare rates are updated and effective on the first of each calendar year based on the Medicare rate update from October of the prior calendar year.

2. Medicaid reimbursement using Medicare codes are updated and effective on the first of each quarter based on the methodology specified in Attachment 4.19-B, Methods and Standards for Establishing Payment Rates.

Payment methods for each service are defined in Attachment 4.19-B, Methods and Standards for Establishing Payment Rates, as referenced. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient services. The fee schedule is published on the agency's website at www.okhca.org/feeschedules.

Service	State Plan Page	Effective Date
Outpatient Hospital Services	Attachment 4.19-B, Page 1	October 1, 2018
A. Emergency Room Services		October 1, 2018
B. Outpatient Surgery	Attachment 4.19-B, Page 1a	October 1, 2018
C. Dialysis Services		October 1, 2018
D. Ancillary Services, Imaging and Other Diagnostic Services		October 1, 2018
E. Therapeutic Services	Attachment 4.19-B, Page 1b	October 1, 2018
F. Clinic Services and Observation/Treatment Room		October 1, 2018
Clinical Laboratory Services	Attachment 4.19-B, Page 2b	October 1, 2018
Physician Services	Attachment 4.19-B, Page 3	October 1, 2018
Home Health Services	Attachment 4.19-B, Page 4	October 1, 2018
Free-Standing Ambulatory Surgery Center-Clinic Services	Attachment 4.19-B, Page 4b	October 1, 2018
Dental Services	Attachment 4.19-B, Page 5	October 1, 2018
Transportation Services	Attachment 4.19-B, Page 6	October 1, 2018
Eyeglasses	Attachment 4.19-B, Page 10.1	October 1, 2018
Nurse Midwife Services	Attachment 4.19-B, Page 12	October 1, 2018
Family Planning Services	Attachment 4.19-B, Page 15	October 1, 2018
Renal Dialysis Facilities	Attachment 4.19-B, Page 19	October 1, 2018
Other Practitioners' Services		
• Anesthesiologists	Attachment 4.19-B, Page 20	October 1, 2018
• Certified Registered Nurse Anesthetists (CRNAs) and Anesthesiologist Assistants	Attachment 4.19-B, Page 20a	October 1, 2018
• Physician Assistants	Attachment 4.19-B, Page 21	October 1, 2018
Nutritional Services	Attachment 4.19-B, Page 21-1	October 1, 2018
4.b. EPSDT		
• Emergency Hospital Services	Attachment 4.19-B, Page 28.1	October 1, 2018
• Speech and Audiologist Therapy Services, Physical Therapy Services, and Occupational Therapy Services	Attachment 4.19-B, Page 28.2	October 1, 2018
Hospice Services	Attachment 4.19-B, Page 28.4	October 1, 2018

DATES FOR ESTABLISHING PAYMENT RATES FOR ATTACHMENT 4.19-B SERVICES

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

Service	State Plan Page	Effective Date
Christian Science Nurses	Attachment 4.19-B, Page 28.5	October 1, 2018
Dentures	Attachment 4.19-B, Page 28.6	October 1, 2018
Respiratory Care	Attachment 4.19-B, Page 28.7	October 1, 2018
Private Duty Nursing Services	Attachment 4.19-B, Page 28.8	October 1, 2018
Physical Therapist	Attachment 4.19-B, Page 28.9	October 1, 2018
Occupational Therapist	Attachment 4.19-B, Page 28.10	October 1, 2018
Christian Science Sanatoria	Attachment 4.19-B, Page 28.11	October 1, 2018
Other Practitioner – Licensed Clinical Social Worker	Attachment 4.19-B, Page 28.12	October 1, 2018
Pediatric or Family Nurse Practitioner (Advanced Practice Nurse) Services	Attachment 4.19-B, Page 32	October 1, 2018

State: Oklahoma
Date Received: 14 September, 2018
Date Approved: 26 November, 2018
Effective Date: 1 October, 2018
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Outpatient Hospital Reimbursement

General

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 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

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 based on the Medicare Ambulatory Surgery Center (ASC) facility services payment system unless otherwise denoted in this section. 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.

1a. Effective on or after January 1, 2018, certain outpatient surgical services provided in an outpatient hospital are reimbursed on a cost basis. Dental and Level 4 ear, nose, and throat (ENT) surgical procedures are classified into a payment group based on CPT codes. A facility specific outpatient cost to charge ratio (CCR) from the hospital Medicare cost report is used to determine average cost per unit by facility, then in total. Each individual procedure code for the dental (D9999) and Level 4 ENT (various codes) will be paid the same cost based single rate set based on statewide hospital costs. These rates will be recalculated annually using the most recent available cost report data from HCRIS.

State: Oklahoma
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Outpatient Hospital Reimbursement *(continued)*

B. Outpatient Surgery *(continued)*

2. Facility fees for surgical procedures not covered as ASC procedures and otherwise covered under Medicaid will be reimbursed according to a state-specific fee schedule based on APC pricing. Bilateral or multiple procedures performed in one day will be subject to discounting.

3. Separate fees for outpatient surgery services are not payable to the hospital if the patient is admitted to the same hospital within 72 hours.

C. Dialysis Services

1. Dialysis visits will be reimbursed at the provider's Medicare composite rate for dialysis services determined by Medicare under 42 CFR 413 subpart H. The facility's composite rate is a comprehensive prospective payment for all modes of facility and home dialysis and constitutes payment for the complete dialysis treatment, except for a physician's professional services, separately billable laboratory services and separately billable drugs.

2. The provider must furnish all of the necessary dialysis services, equipment and supplies. Reimbursement for dialysis services and supplies is further defined in the Medicare Provider Reimbursement Manual, HCFA Pub. 15 (referred to as "Pub. 15"). For purposes of specifying the services covered by the composite rate and the services that are separately billable, the agency hereby adopts and incorporates herein by reference Pub. 15.

D. Ancillary Services, Imaging and Other Diagnostic Services

Ancillary services, imaging services, and other diagnostic services will be reimbursed on a prospective basis by paying the lower of usual and customary charges or a fee basis.

1. Services such as physical, occupational, and speech therapy services are reimbursable at a flat statewide fee schedule rate. The rate is based on APC group 0600.

2. For each imaging service or procedure, the fee will be the technical component of the Medicare resource-based relative value scale (RBRVS).

3. For each diagnostic service or procedure, the fee will be the technical component of the RBRVS. For those services where there is no technical component under RBRVS, the fee will be 100 percent of the global value.

~~4.~~ A facility fee will be reimbursed to the hospital for the services listed in D.2-3 in accordance with the methodology described in F. below.

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Pen and Ink Correction:
Red Text changed to black
12/20/18 sss

Revised 10-01-18

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Outpatient Hospital Reimbursement *(continued)*

E. Therapeutic Services

1. Payment is made for drugs and supplies for outpatient chemotherapy. A separately billable facility fee payment is made for administration based on Medicare APC group 0117. Claims cannot be filed for an observation room, clinic, or ER visits on the same day.

2. For each therapeutic radiology service or procedure, payment will be the technical component of the Medicare RBRVS.

F. Clinic Services and Observation/Treatment Room

A fee will be established for clinic visits and certain observation room visits. Reimbursement is limited to one unit per day per patient, per provider. The payment rates are based on APC groups 601 and 0339, respectively. Separate payment will not be made for observation room following outpatient surgery.

G. Hospital-based Community Mental Health Centers (CMHCs) Operated by Units of Government

1. CMHCs will be paid on the basis of cost in accordance with the following methodology: An overall outpatient cost-to-charge ratio (CCR) for each hospital will be calculated using the most recently available cost reports, with data taken from Worksheet C, Part 1. The overall CCR for each hospital will be applied to the Medicaid charges for the state fiscal year to determine the Medicaid costs for the year.

2. The agency's fee schedule rates are set as of July 1, 2006 and in effect for services provided on or after that date. All rates are published on the agency's website located at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

3. Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%

H. Partial Hospitalization Services (PHP)

PHP services are provided in accordance with 42 CFR 410.43

Any child 0-20 that is an eligible member and who meets the medical necessity and programmatic criteria for behavioral health services qualifies for PHP. Treatment is time limited and must be offered a minimum of 3 hours per day, 5 days a week. Therapeutically intensive clinical services are limited to 4 billable hours per day. Services are prior authorized for 1-3 months based on medical necessity criteria.

The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse vendor. An initial prior authorization will be required by OHCA or its designated agent. This initial prior authorization will ensure that the level of service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Clinic Laboratory Services

Payment will be made for covered clinical laboratory services at rates not to exceed 100% of the CMS National Laboratory Fee Schedule, or at rates not to exceed 100% of the local Medicare Carrier's allowable charge for procedures not included in the National Laboratory Fee Schedule, or in instances where no national or local fee has been established, an interim fee will be established by the State Plan Amendment Rate Committee of the Oklahoma Health Care Authority.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

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 the Medicare conversion factor (CF). The Medicare 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.

Effective 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.

Vaccines are paid the equivalent to Medicare Part B, ASP + 6%. When ASP is not available, an equivalent price is calculated using Wholesale Acquisition Cost (WAC). If no Medicare, ASP, or WAC pricing is available, then the price will be calculated based on invoice cost. No payment will be made to physicians or other practitioners for vaccines that were received through the Vaccine for Children's program.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Home Health Services

Payment is made at the fee schedule amount for skilled visits and home health aide visits.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Free-Standing Ambulatory Surgery Center-Clinic

A. Payment for outpatient surgical procedures that are covered under Medicare's ASC payment system will be reimbursed 100 percent of the 2005 Medicare rate for such services. 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.

B. Facility fees for surgical procedures not covered as Medicare ASC procedures and otherwise covered under Medicaid, will be reimbursed according to a State-specific fee schedule taking into consideration rates for Medicare Ambulatory Patient Classification (APC) pricing and reimbursement for similar services provided in the outpatient hospital setting. Bilateral or multiple procedures performed in one day will be subject to discounting.

C. The fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency secure website and/or public website. The fee schedule will not exceed the upper payment limit (UPL) at 42 CFR 447.321 Outpatient hospital and clinic services: Application of upper payment limits. A uniform rate is paid to governmental and non-governmental providers.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment to Dentists for General Dental and Orthodontic Services

Dentists are reimbursed a fee for service rate for general dental and orthodontic services. The same rate is paid for each service regardless of where the service was provided.

In addition, the reimbursement methodology for amalgam or posterior composite resin restorations which is the mean of the 2009 reimbursement rates for each, will be reduced by 3.00% along with all other dental fees effective 07-01-10.

Payments to Dentists Working at a Governmental Hospital Based Children's Dental Clinic

The State reimburses these dentists a fee-for-service amount that equals the average commercial fee schedule, which is calculated in the following manner. For each of the dental procedures rendered by dentists in this dental clinic, the State determined the average commercial allowed amount paid per procedure code by the top five commercial payers. The fee schedule amount for each dental procedure code equals an average of the payment by the top payers. The average commercial fee schedule rate provides for payment in-full and is not an add-on payment to the regular Medicaid rate.

In addition, the reimbursement methodology for amalgam or posterior composite resin restorations which is the mean of the 2009 reimbursement rates for each, will be reduced by 3.00% along with all other dental fees effective 07-01-10.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Transportation

Payment is made for the least expensive means of transportation commensurate with the patient's needs.

Ground Ambulance Transports – Payment will be made for each level of service based on the geographically adjusted Medicare Ambulance Fee Schedule (AFS).

A. Air Ambulance Transports – Reimbursement for air ambulance service is made based on the Medicare AFS. Payment will not exceed 100% of the Medicare allowable rates.

1. Rotary Wing (RW) - Payment to providers affiliated with Level I Trauma Centers is based on a blend of the urban and rural rates for both the base payment and the mileage rate. The blended ratio is .41/.59 for the POP. The rate for base and mileage for all other RW providers is based on the urban rate, regardless of the POP.

2. Fixed wing (FW) – Payment is calculated using the urban base rate and mileage, regardless of the POP. Effective with claims for dates of service on or after July 1, 2008, reimbursement is made based on the 2008 Medicare AFS.

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METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for other services and supplies *(continued)*

(b) Eyeglasses *(continued)*

Reimbursement for eyeglass materials is set at a flat rate for the frame and the single vision and bifocal vision lenses. All lenses are made of polycarbonate material except in those instances where polycarbonate materials are not appropriate due to the refraction requirements. Polycarbonate will not be reimbursed separately. Refraction and fitting fee are reimbursed separately.

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Revised 10-01-18

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Renal Dialysis Facilities

Payment is made at the Medicare allowable facility rate. This rate includes all services which Medicare has established as an integral part of the dialysis procedure.

Effective for services provided on or after July 1, 2012, payment is made at the Medicare wage adjusted base rate.

The ESRD PPS is a single payment to ESRD facilities that will cover all the resources used in furnishing an outpatient dialysis treatment; the supplies and equipment that administer dialysis, drugs, biological, lab tests, and training and support services. Separately billable items include: vaccines, telehealth, and blood and blood products.

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Pen and Ink Correction:
Date corrected 12/20/18 sss

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Anesthesiologists

Effective January 1, 2014, the anesthesia procedure codes listed in the 2014 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 a conversion factor approved by the agency's internal rate setting committee. 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 set by agency's internal rate setting committee for one unit of service regardless of the base and time units involved in the procedure.

Anesthesia CPT Code 01996 will be reimbursed at a maximum reimbursement amount based on a formula involving base units and multiplied by the current conversion factor regardless of the time units involved in the procedure.

For services rendered effective January 1, 2008, the base unit values for the anesthesia codes (CPT Codes 00100 through 01966 and 01968 through 01999) were 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 or CRNA) 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 and CRNAs 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 $39.00 the reimbursement is calculated as follows:

$$(4b+6u) \times \$39.00 = \$390.00$$

Time is reported in "units" where each unit is expressed in 15 minute increments and will be as follows:

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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.	

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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:

2014 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 (CRNA)

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 CRNAs 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 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.

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 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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

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

d. Hospice Services *(continued)*

6. **Other General Reimbursement Items**

(b) **Hospice payment rates.** The rates for hospice services are set by applying the full Medicaid daily rate, published annually by CMS for hospice services, then applying any applicable rate reduction percentages to the full Medicaid daily rate. The aforementioned rate methodology is used by the State unless the rate is less than the CMS established floor; in which case, the floor rates are calculated by taking the Medicaid Hospice rates provided by CMS, applying the wage index to the wage component subject to index, and adding the non-weighted amount.

Under the Medicaid hospice benefit, no cost sharing may be imposed with respect to hospice services rendered to Medicaid recipients.

Rates will not be less than Medicaid hospice rates established under Medicare adjusted by the wage index.

7. **Obligation of continuing care**

After the member's Medicare hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide the recipient's care until the patient expires or until the member revokes the election of hospice care.

8. **Payment for physician services**

The basic rates for hospice care represent full reimbursement to the hospice for the costs of all covered services related to the treatment of the member's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice. The physician serving as the medical director and the physician member of the hospice interdisciplinary group would generally perform these activities. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care.

Reimbursement for an independent physician's direct patient services is made in accordance with the usual SoonerCare reimbursement methodology for physician services. These services will not be billed by the hospice under the hospice provider number. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or x-rays are not to be included on the attending physician's billed charges to the Medicaid program. The aforementioned charges are included in the daily rates paid and are expressly the responsibility of the hospice.

9. **Limitations**

Payment is made for home based hospice services for terminally ill individuals with a life expectancy of six months or less when the member and/or family has elected hospice benefits. Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the member's lifetime. A hospice physician or nurse practitioner must have a face to face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter; and the practitioner attests in the medical record that such visit took place.