

## Oklahoma Health Care Authority

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

**OHCA COMMENT DUE DATE:** January 2, 2024

The proposed policy changes are Permanent Rules. The proposed policy changes were presented at the Tribal Consultation held on October 31, 2023. The proposed rule changes will be presented at a Public Hearing on January 8, 2024. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on January 4, 2024, and the OHCA Board of Directors on January 17, 2024.

**REFERENCE: APA WF 23-24**

### **SUMMARY:**

**Update and Clarify Policy Regarding Coverage of Prosthetic Hearing Implants and Audiology Services for Adults** - The agency proposes rule revisions to clarify coverage of prosthetic hearing implants and ocular prosthetics for adults in the expansion population. These services and devices are authorized within the Medicaid State Plan; these revisions will clarify coverage for these devices and the surrounding services.

### **LEGAL AUTHORITY:**

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

### **RULE IMPACT STATEMENT:**

#### **STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY**

**SUBJECT:** Rule Impact Statement  
APA WF # 23-24

**A. Brief description of the purpose of the rule:**

The Title XIX Alternative Benefit Plan authorizing the benefit package for expansion adults includes coverage of prosthetic devices. Prosthetic hearing implants (cochlear and other hearing implant devices) and Ocular prosthetics are covered for this population and this coverage will now be reflected in the rules.

Updates to policy are needed to include and/or clarify coverage for these devices as well as the surrounding audiology services required pre and post implant.

**B. A description of the classes of persons who most likely will be affected by the proposed rule,**

including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

No classes of persons will be affected by this rule.

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

Expansion adults will benefit as rules clarify that this population is eligible to receive ocular prosthetics and cochlear implants.

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

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

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

Agency staff has determined that the proposed rule changes are budget neutral.

- 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 subdivisions 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 proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

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

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

- I. A determination of the effect of the proposed rule on the public health, safety, and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety, and environment, an explanation of the nature of the risk and to what extent

the proposed rule will reduce the risk:

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

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

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

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

Prepared: November 14, 2023

Modified: November 27, 2023

**RULE TEXT:**

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 3. GENERAL MEDICAL PROGRAM INFORMATION**

**317:30-3-57. General SoonerCare coverage - categorically needy**

The following are general SoonerCare coverage guidelines for the categorically needy:

- (1) Inpatient hospital services.
  - (A) Adult coverage for inpatient hospital stays as described at Oklahoma Administrative Code (OAC) 317:30-5-41.
  - (B) Coverage for members under twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.
- (2) Emergency department services.
- (3) Dialysis in an outpatient hospital or freestanding dialysis facility.
- (4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.
- (5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with the Oklahoma Health Care Authority (OHCA).
- (6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified hospital-based facilities that are also qualified mental health clinics.
- (7) Rural health clinic services and other ambulatory services furnished by rural health clinic.
- (8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.
- (9) Maternity clinic services.

- (10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the Agency's Medical Authorization Unit.
- (11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.
- (12) Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).
- (13) Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA child-health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.12.
- (A) EPSDT screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.
  - (B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.
  - (C) Immunizations.
  - (D) Outpatient care.
  - (E) Dental services as outlined in OAC 317:30-3-65.8.
  - (F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
  - (G) Hearing services as outlined in OAC 317:30-3-65.9.
  - (H) Prescribed drugs.
  - (I) Outpatient psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.
  - (J) Inpatient psychiatric services as outlined in OAC 317:30-5-94 through 317:30-5-97.
  - (K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.
  - (L) Inpatient hospital services.
  - (M) Medical supplies, equipment, appliances, orthotics and prosthetics.
  - (N) EPSDT services furnished in a qualified child health center.
- (14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members twenty-one (21) years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least thirty (30) days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

- (15) Physicians' services whether furnished in the office, the member's home, a hospital, a long-term care facility, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).
- (16) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider section for limitations to covered services for:
- (A) Podiatrists' services;
  - (B) Optometrists' services;
  - (C) Psychologists' services;
  - (D) Certified registered nurse anesthetists;
  - (E) Certified nurse midwives;
  - (F) Advanced practice registered nurses; and
  - (G) Anesthesiologist assistants.
- (17) Freestanding ambulatory surgery centers.
- (18) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:
- (A) Unlimited medically necessary monthly prescriptions for:
    - (i) Members under the age of twenty-one (21) years; and
    - (ii) Residents of long-term care facilities or ICF/IID.
  - (B) Seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) home and community-based services (HCBS) waivers. These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.
- (19) Rental and/or purchase of medical supplies, equipment, and appliances.
- (20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.
- (21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).
- (22) For non-expansion adults, prosthetic devices are limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure. There is no coverage for orthotic devices for adults.
- (23) Orthotics and prosthetics, including ocular prosthetic and cochlear implants, are covered for expansion adult members, above the limitations within (22) of this Section, when prescribed by the treating provider (physician, physician assistant, or an advanced practice registered nurse) and medical necessity is documented in accordance with OAC 317:30-5-211.13.
- (24) Standard medical supplies.
- (25) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and

determined to be medically necessary.

(26) Blood and blood fractions for members when administered on an outpatient basis.

(27) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.

(28) Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.

(29) Inpatient psychiatric facility admissions for members are limited to an approved length of stay with provision for requests for extensions.

(30) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.

(31) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for twelve (12) months after the pregnancy ends regardless of the reason, beginning on the last date of pregnancy.

(32) Long-term care facility services for members under twenty-one (21) years of age.

(33) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a registered nurse (RN).

(34) Medicare Part A, Part B, and Part C deductibles, coinsurance, and copays.

(35) HCBS for the intellectually disabled.

(36) Home health services can be provided without a PA for the first thirty-six (36) visits. A PA will be required beyond the 36<sup>th</sup> visit. The visits are limited to any combination of RN and nurse aide visits.

(37) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

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

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

(C) All organ transplants must be performed at a Medicare approved transplantation center;

(D) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and

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

(38) HCBS for intellectually disabled members who were determined to be inappropriately placed in a long-term care facility (Alternative Disposition Plan - ADP).

(39) Case management services for the chronically and/or seriously mentally ill.

(40) Emergency medical services, including emergency labor and delivery for undocumented or ineligible aliens.

(41) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.

(42) Early intervention services for children ages zero (0) to three (3).

(43) Residential behavior management in therapeutic foster care setting.

(44) Case management services through the Oklahoma Department of Mental Health and

Substance Abuse Services (ODMHSAS).

(45) HCBS for aged or physically disabled members.

(46) Outpatient ambulatory services for members infected with tuberculosis.

(47) Smoking and tobacco use cessation counseling for children and adults.

(48) Services delivered to American Indians/Alaskan Natives (AI/AN) in Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us). Payment is made on an encounter basis.

(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

(50) Residential substance use disorder (SUD) services.

(51) Medication-assisted treatment (MAT) services.

(52) Diabetes self-management education and support (DSMES).

## **SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

### **PART 17. MEDICAL SUPPLIERS**

#### **317:30-5-211.13. Orthotics and prosthetics**

(a) Coverage of prosthetics for non-expansion adults is limited to (1) home dialysis equipment and supplies, (2) nerve stimulators, (3) external breast prosthesis and support accessories, and (4) implantable devices inserted during the course of a surgical procedure. Prosthetics prescribed by an appropriate qualified provider and as specified in this section are covered items for non-expansion adults. There is no coverage of orthotics for non-expansion adults.

(1) **Home dialysis.** Equipment and supplies are covered items for members receiving home dialysis treatments only.

(2) **Nerve stimulators.** Payment is made for transcutaneous nerve stimulators, implanted peripheral nerve stimulators, and neuromuscular stimulators.

(3) **Breast prosthesis, bras, and prosthetic garments.**

(A) Payment is limited to:

(i) One (1) prosthetic garment with mastectomy form every twelve (12) months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(ii) Two (2) mastectomy bras per year; and

(iii) One (1) silicone or equal breast prosthetic per side every twenty-four (24) months; or

(iv) One (1) foam prosthetic per side every six (6) months.

(B) Payment will not be made for both a silicone and a foam prosthetic in the same twelve (12) month period.

(C) Breast prostheses, bras, and prosthetic garments must be purchased from a Board Certified Mastectomy Fitter.

(D) A breast prosthesis can be replaced if:

(i) Lost;

(ii) Irreparable damaged (other than ordinary wear and tear); or

(iii) The member's medical condition necessitates a different type of item and the physician provides a new prescription explaining the need for a different type of

prosthesis.

(E) External breast prostheses are not covered after breast reconstruction is performed except in instances where a woman with breast cancer receives reconstructive surgery following a mastectomy, but the breast implant fails or ruptures and circumstances are such that an implant replacement is not recommended by the surgeon and/or desired by the member.

(4) **Prosthetic devices inserted during surgery.** Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

(b) Orthotics and prosthetics are covered for expansion adults services when:

(1) Orthotics are medically necessary when required to correct or prevent skeletal deformities, to support or align movable body parts, or to preserve or improve physical function.

(2) Prosthetics, including ocular prosthetic and cochlear implants, are medically necessary as a replacement for all or part of the function of a permanently inoperative, absent, or malfunctioning body part. The member shall require the prosthesis for mobility, daily care, or rehabilitation purposes.

(3) In addition, orthotics and prosthetics must be:

(A) A reasonable and medically necessary part of the member's treatment plan;

(B) Consistent with the member's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the member; and

(C) Of high quality, with replacement parts available and obtainable.

(c) Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.1 for definitions of orthotics and prosthetics.