TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-1. Eligible providers

To allow patients free choice of physicians, the Oklahoma Health Care Authority (OHCA) recognizes all licensed medical and osteopathic physicians as being eligible to receive payment for compensable medical services rendered in behalf of a person eligible for such care in accordance with the rules and regulations covering the Authority's medical care programs. Payment will be made to fully licensed physicians who are participating in medical training programs as students, interns, residents, or fellows, or in any other capacity in training for services outside the training setting and are not in a duplicative billing situation. In addition, payment will be made to the employing facility for services provided by physicians who meet all requirements for employment by the Federal Government as a physician and are employed by the Federal Government in an IHS facility or who provide services in a 638 Tribal Facility. Payment will not be made to a provider who has been suspended or terminated from participation in the program.

(1) Payment to physicians under ~~Medicaid~~ SoonerCare is made for services clearly identifiable as personally rendered services performed on behalf of a specific patient. There are no exceptions to personally rendered services unless specifically set out in coverage guidelines.

(2) Payment is made to the attending physician in a teaching medical facility for compensable services when he/she signs as claimant, and renders personal and identifiable services to the patient in conformity with Federal regulations. ~~Payment will be made to a physician for supervising the services of a CRNA unless the CRNA bills directly.~~

(3) Payment is made to a physician for medically directing the services of a Certified Registered Nurse Anesthetist (CRNA) at a rate of 50% of the physician allowable for anesthesia services.

(4) Payment is made to a physician for the direct supervision of an Anesthesiologist Assistant (AA) at a rate of 50% of the physician allowable for anesthesia services. Direct supervision means the on-site, personal supervision by an anesthesiologist who is present in the office, or is present in the surgical or obstetrical suite

when the procedure is being performed and who is in all instances immediately available to provide assistance and direction to the AA while anesthesia services are being performed.

317:30-5-2. General coverage by category

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA's) medical programs, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgicenter or a Medicare certified hospital that offers outpatient surgical services. Refer to the List of Covered Surgical Procedures.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies or opportunistic infections.

(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.

(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare patient, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

(I) Diagnostic x-ray and laboratory services.
(J) Mammography screening and additional follow-up mammograms.
(K) Obstetrical care.
(L) Pacemakers and prostheses inserted during the course of a surgical procedure.
(M) Prior authorized examinations for the purpose of determining medical eligibility for programs under the jurisdiction of the Authority. A copy of the authorization, OKDHS form ABCDM-16, Authorization for Examination and Billing, must accompany the claim.
(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and, executes the federally mandated consent form with his/her physician . A copy of the consent form must be attached to the claim form. Separate payment is allowed for I.U.D. insertion during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.
(P) Genetic counseling (requires special medical review prior to approval).
(Q) Weekly blood counts for members receiving the drug Clozaril.
(R) Complete blood count (CBC) and platelet count prior to receiving chemotherapeutic agents, radiation therapy or medication such as DPA-D-Penacillamine on a regular basis for treatment other than for malignancy.
(S) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.
(T) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.

(U) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:

(i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;

(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;

(iii) Hold unrestricted license to practice medicine in Oklahoma;

(iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;

(v) Seeing members without supervision;

(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;

(vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number.

(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.

(V) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.

(i) Attending physician performs chart review and sign off on the billed encounter;

(ii) Attending physician present in the clinic/or hospital setting and available for consultation;

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(W) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:

(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) The contact must be documented in the medical record.

(X) The ~~Payment~~ payment to a physician for ~~supervision~~ medically directing the services of a CRNA or for the direct supervision of the services of an Anesthesiologist Assistant (AA) is limited ~~services unless the CRNA bills directly~~. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

(Y) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.

(Z) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adult are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

(i) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(iv) Procedures considered experimental or investigational are not covered.

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

(i) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure.

(ii) Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.

(BB) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.

(CC) Ventilator equipment.

(DD) Home dialysis equipment and supplies.

(EE) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and

prescriptions. Drugs prescribed for the treatment of TB not listed in OAC 317:30-3-46 require prior authorization by the College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(FF) Smoking and Tobacco Use Cessation Counseling for treatment of individuals using tobacco.

(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:

(I) Asking the member to describe their smoking use;

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;

(IV) Assisting the member with referrals and plans to quit; and

(V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, nurse practitioners, nurse midwives, dentists, and Oklahoma State Health Department and FQHC nursing staff. It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP capitation payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note and signature along with the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(GG) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(2) General coverage exclusions include the following:

(A) Inpatient diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.
(C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.
(D) Refractions and visual aids.
(E) A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care.
(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(H) Non-therapeutic hysterectomy.
(I) Medical services considered to be experimental or investigational.
(J) Payment for more than four outpatient visits per month (home or office) per member except those visits in connection with family planning, or related to emergency medical conditions.
(K) Payment for more than two nursing facility visits per month.
(L) More than one inpatient visit per day per physician.
(M) Physician supervision of hemodialysis or peritoneal dialysis.
(N) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.
(O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(P) Payment for the services of physicians' assistants, social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(Q) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury, or illness related to a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

(R) Night calls or unusual hours.

(S) Speech and Hearing services.

(T) Mileage.

(U) A routine hospital visit on the date of discharge unless the member expired.

(V) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(W) Inpatient chemical dependency treatment.

(X) Fertility treatment.

(Y) Payment for removal of benign skin lesions unless medically necessary.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's medical programs, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) ~~Effective October 1, 1993, all~~ All residential and acute psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25,317:30-5-95.27 and 317:30-5-95.29.

(B) Out of state placements will not be authorized unless it is determined that the needed medical

services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment program.** Payment is made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Title 21, Oklahoma Statutes, Section 846, as amended, states in part: *Every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic physicians, residents, and interns,*

examining, attending, or treating a child under the age of eighteen (18) years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of eighteen (18) years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above. Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought as a result of the report.

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

(A) Inpatient diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the codes for subsequent hospital care must be used.

(D) A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care.

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of persons who are under 21 years of age.

(G) Non-therapeutic hysterectomy.

(H) Medical Services considered to be experimental or investigational.

(I) More than one inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or ~~317:30-5-50~~ 317:30-5-50.)

(K) Physician supervision of hemodialysis or peritoneal dialysis.

(L) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.

(M) Payment for the services of physicians' assistants except as specifically set out in OHCA rules.

(N) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(P) Night calls or unusual hours.

(Q) Mileage.

(R) A routine hospital visit on date of discharge unless the member expired.

(S) Tympanometry.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment or within one year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment or within one year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for the denial.

PART 69. CERTIFIED REGISTERED NURSE ANESTHETISTS

317:30-5-605. Eligible providers

~~Effective for services provided on or after April 1, 1987 payment~~ Payment is made directly to Certified Registered Nurse Anesthetists (CRNA) for compensable anesthesia services within their scope of practice under state law. The CRNA must be licensed to practice under applicable ~~State Laws~~ state laws. In addition, the CRNA must have a current ~~Memorandum of Agreement~~ provider contract on file with the Oklahoma Health Care Authority (OHCA).

317:30-5-606. Coverage by category

Payment is made to certified registered nurse anesthetists as set forth in this Section.

(1) **Adults.** Payment is made for the administration of anesthesia to adults within the scope of the Authority's medical programs, provided the services are reasonable and necessary for the treatment of illness or injury, or to improve the functioning of a malformed body member.

(2) **Children.** Coverage for children is the same as for adults.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

317:30-5-607. Billing instructions

The CRNA is responsible for entering the correct anesthesia procedure code on the appropriate claim form. Anesthesia codes from the Physicians' Current Procedural Terminology or Medicare assigned codes should be used.

(1) Payment is made only for the major procedure during an operative session.

(2) All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied. Payment to the CRNA is limited to 80% of the physician allowable for anesthesia services without medical direction using modifier QZ and 50% of the physician allowable when services are provided under the medical direction of an anesthesiologist using modifier QX.

(3) Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. Additional payment can be made when applicable for

extremes of age, total body hypothermia and controlled hypertension.

(4) All other qualifying circumstances, i.e., physical status, emergency, etc., have been structured into the total allowable for the procedure.

(5) Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by the Authority's Medical Consultants.

(6) Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

~~**317:30-5-608. Elective sterilizations**~~

~~(a) Payment is made to certified registered nurse anesthetists for elective sterilizations performed in behalf of eligible individuals if all of the following circumstances are met:~~

~~(1) The patient must be at least 21 years of age at the time the consent form is signed,~~

~~(2) The patient must be mentally competent,~~

~~(3) A properly completed Federally mandated consent for sterilization form is attached to the claim, and~~

~~(4) The form is signed and dated at least 30 days, but not more than 180 days prior to the surgery.~~

~~(b) A copy of the consent for sterilization should be obtained from the surgeon or the hospital and attached to the claim form.~~

~~**317:30-5-609. Hysterectomies**~~

~~(a) A hysterectomy performed for purposes of sterilization or family planning is not compensable.~~

~~(b) Payment is made to certified registered nurse anesthetists for therapeutic hysterectomies only when one of the following circumstances is met:~~

~~(1) A properly completed hysterectomy acknowledgement is attached to the claim form. The acknowledgement must clearly state that the patient or her representative was informed, orally and in writing, prior to the surgery that she would be rendered permanently incapable of reproduction.~~

~~(2) The 30 day waiting period which applies to elective sterilizations does not apply to therapeutic hysterectomies.~~

~~(3) The surgeon must certify in writing that the patient was sterile prior to the surgery. The reason for the~~

~~sterility, i.e., post-menopausal, previous tubal ligation, etc, must be given.~~

~~(4) The surgeon must certify that the surgery was performed in an emergency, life endangering situation. The circumstances must be given.~~

~~(c) Documentation to meet one of the situations in (b) of this Section should be obtained from the surgeon or the hospital and attached to the claim form.~~

~~317:30-5-610. Abortions~~

~~(a) Payment is made only for abortions in those instances where the abortion is necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or where the pregnancy is the result of an act of rape or incest. Medicaid coverage for abortions to terminate pregnancies that are the result of rape or incest will only be provided as long as Congress considers abortions in cases of rape or incest to be medically necessary services and federal financial participation is available specifically for these services.~~

~~(1) For abortions necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, the physician must certify in writing that the abortion is being performed due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. The mother's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.~~

~~(2) For abortions in cases of rape or incest, there are two requirements for the payment of a claim. First, the patient must fully complete the Patient Certification for Medicaid Funded Abortion. Second, the patient must have made a police report or counselor's report of the rape or incest.~~

~~(b) The Oklahoma Health Care Authority performs a "look-behind" procedure for abortion claims paid from Medicaid funds. This procedure will require that this Agency obtain the complete medical records for abortions paid under Medicaid. On a post-payment basis, this Authority will~~

~~obtain the complete medical records on all claims paid for abortions.~~

~~(c) Claims for spontaneous abortions, including dilation and curettage, do not require certification. The following situations also do not require certification:~~

~~(1) If the physician has not induced abortion, counseled or otherwise collaborated in inducing the abortion; and~~

~~(2) If the process has irreversibly commenced at the point of the physician's medical intervention.~~

~~(d) Claims for the diagnosis "incomplete abortion" require medical review.~~

~~(e) The appropriate diagnosis codes should be used indicating spontaneous abortion, etc., otherwise the procedure will be denied.~~

317:30-5-611. Payment methodology

~~When payment is made directly to a CRNA, such payment will be made at the rate of 80 percent of the allowable for anesthesia services.~~

Payment to the CRNA is limited to 80% of the physician allowable for anesthesia services performed without medical direction and 50% of the physician allowable when services are provided under the medical direction of a licensed physician.

PART 70. ANESTHESIOLOGIST ASSISTANTS

317:30-5-612. Eligible providers

Payment is made directly to Anesthesiologist Assistants (AA) for compensable anesthesia services within their scope of practice under state law. The AA must be licensed to practice under applicable state laws. In addition, the AA must have a current provider contract on file with the Oklahoma Health Care Authority (OHCA).

317:30-5-613. Coverage by category

Payment is made to Anesthesiologist Assistants as set forth in this Section.

(1) **Adults.** Payment is made for the administration of anesthesia to adults within the scope of the Authority's medical programs, provided the services are reasonable and necessary for the treatment of illness or injury, or to improve the functioning of a malformed body member.

(2) **Children.** Coverage for children is the same as for adults.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

317:30-5-614. Billing instructions

The AA is responsible for entering the correct anesthesia procedure code on the appropriate claim form. Anesthesia codes from the Physicians' Current Procedural Terminology or Medicare assigned codes should be used.

(1) Payment is made only for the major procedure during an operative session.

(2) All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied. Payment is made to an AA for services provided under the direct supervision of a licensed anesthesiologist and is limited to 50% of the physician allowable using modifier QX.

(3) Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. Additional payment can be made when applicable for extremes of age, total body hypothermia and controlled hypertension.

(4) All other qualifying circumstances, i.e., physical status, emergency, etc., have been structured into the total allowable for the procedure.

(5) Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by the Authority's Medical Consultants.

(6) Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

317:30-5-615. Payment methodology

Payment to the AA is limited to 50% of the physician allowable for anesthesia services.