REBECCA PASTERNIK-IKARD
CHIEF EXECUTIVE OFFICER

J. KEVIN STITT
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

OHCA 2019-16

August 13, 2019

RE: Clarification of Laboratory Services Policy Changes

Dear Provider,

The Oklahoma Health Care Authority (OHCA) recently updated Oklahoma Administrative Code (OAC) 317:30-5-20 Laboratory Services. These updates were first promulgated through the 2018 legislative session as an emergency rule and then promulgated through the 2019 legislative session as a permanent rule per the Oklahoma Administrative Procedures Act.

The OHCA would like to clarify that appropriate screening services, such as those found in the American Academy of Pediatrics (AAP) Bright Futures' periodicity schedule, the United States Preventive Services Task Force (USPSTF) A and B recommendations, the American Academy of Family Physicians' (AAFP) clinical recommendations, or other nationally-recognized medical professional academy or society standards of care, are covered benefits for SoonerCare members. Additionally, such sources should meet medical necessity criteria as outlined in OAC 317:30-3-1(f) (attached).

If you have any questions, please call the OHCA Provider Helpline at 1-800-522-0114.

Thank you for your continued service to our SoonerCare members.

Sincerely,

Rebecca Pasternik-Ikard

Rebecca Pasternik-Ikard
Chief Executive Officer

317:30-3-1. Creation and implementation of rules; applicability
[Revised 01-23-01]
(a) Medical rules of the Oklahoma Health Care Authority (OHCA) are set by the Oklahoma Health Care Authority Board. The rules are based upon the recommendations of the Chief Executive Officer of the Authority, the Deputy Administrator for Health Policy, the Medicaid Operations State Medicaid Director, and the Advisory Committee on Medical Care for Public Assistance Recipients. The Medicaid Operations State Medicaid Director is responsible for implementing medical policies and programs and directing the Fiscal Agent with regard to proper payment of claims.
(b) Payment to practitioners under Medicaid 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.
(c) Payment is made on behalf of Medicaid eligible individuals for services within the scope of the Authority medical programs. Services cannot be paid under Medicaid for ineligible individuals or for services not covered under the scope of medical programs or that do not meet documentation requirements. These claims will be denied, or in some instances upon post-payment review, payment will be recouped.
(d) Payment to practitioners on behalf of Medicaid eligible individuals is made only for services that are medically necessary and essential to the diagnosis and treatment of the patient's presenting problem. Well patient examinations and diagnostic testing are not covered for adults unless specifically set out in coverage guidelines.
(e) The scope of the medical program for eligible children is the same as for adults except as further set out under EPSDT.
(f) Services provided within the scope of the Oklahoma Medicaid Program shall meet medical necessity criteria. Requests by medical services providers for services in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority shall serve as the final authority pertaining to all determinations of medical necessity. Medical necessity is established through consideration of the following standards:
(1) Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability;
(2) Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records, evidence sufficient to justify the client's need for the service;

(3) Treatment of the client's condition, disease or injury must be based on reasonable and predictable health outcomes;

(4) Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the client, family, or medical provider;

(5) Services must be delivered in the most cost-effective manner and most appropriate setting; and

(6) Services must be appropriate for the client's age and health status and developed for the client to achieve, maintain or promote functional capacity.

(g) Emergency medical condition means a medical condition including injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

(h) Verbal or written interpretations of policy and procedure in singular instances is made on a case by case basis and shall not be binding on this Agency or override its policy of general applicability.

(i) The rules and policies in this part apply to all providers of service who participate in the program.