Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: May 31, 2014

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on May 15, 2014 and the OHCA Board of Directors on June 12, 2014.

Reference: APA WF 14-08

SUMMARY:
Limiting Reimbursement for Eyeglasses — Rules are amended to limit the number of payments for glasses to two per year. Any additional glasses beyond this limit must be prior authorized and determined to be medically necessary. These changes are needed in order to reduce the overall costs of the Medicaid program.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Isaac Lutz
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 14-08

A. Brief description of the purpose of the rule:

Rules are amended to limit the number of payment for glasses to two per year. Any additional glasses beyond this limit must be prior authorized and determined to be medically necessary.
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:

Children who are enrolled in SoonerCare and request multiple pairs of eyeglasses annually may be affected by the proposed rule.

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

No classes of persons will benefit from the proposed rule.

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 affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The rule change has total projected total budget savings of $347,055; state savings are projected as $129,347.

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:

There is no economic impact on political subdivisions.

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:
There is no adverse economic impact on small businesses as a result of this rule.

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:

Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

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

The rule impact statement was prepared April 30, 2014.

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 other than those provided in an institution for mental diseases.
   (A) Adult coverage for inpatient hospital stays as described at OAC 317:30-5-41.
   (B) Coverage for members under 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 free standing 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 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) Nursing facility services (other than services in an institution for tuberculosis or mental diseases).
(13) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under 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 317:30-3-65.4.
(A) Child health 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 visual screening and glasses each 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 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 OAC 317:30-5-278.
(J) Inpatient Psychotherapy services and psychological testing as outlined in OAC 317:30-5-95 through OAC 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 and prosthetic devices beyond the normal scope of SoonerCare.
(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 21 years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least 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 nursing facility, ICF/MRICF/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 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 Nurses
   (G) Anesthesiologist Assistants

(17) Free-standing ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six prescriptions with a limit of two brand name prescriptions per month. Exceptions to the six prescription limit are:
   (A) unlimited medically necessary monthly prescriptions for:
      (i) members under the age of 21 years; and
      (ii) residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded
   (B) seven medically necessary generic prescriptions per month in addition to the six covered under the State Plan are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. These additional medically necessary prescriptions beyond the two brand name or thirteen total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of durable medical equipment.

(20) Adaptive equipment, when prior authorized, for members residing in private ICF/MR's.

(21) Dental services for members residing in private ICF/MR's in accordance with the scope of dental services for members under age 21.

(22) Prosthetic devices 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.

(23) Standard medical supplies.
(24) Eyeglasses under EPSDT for members under age 21. Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

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

(26) Inpatient services for members age 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.

(27) Nursing facility services, limited to members preauthorized and approved by OHCA for such care.

(28) Inpatient psychiatric facility admissions for members under 21 are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.

(29) 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.

(30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last date of pregnancy.

(31) Nursing facility services for members under 21 years of age.

(32) 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 R.N.

(33) Part A deductible and Part B Medicare Coinsurance and/or deductible.

(34) Home and Community Based Waiver Services for the intellectually disabled.

(35) Home health services limited to 36 visits per year and standard supplies for 1 month in a 12-month period. The visits are limited to any combination of Registered Nurse and nurse aide visits, not to exceed 36 per year.

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

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

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

(D) Finally, procedures considered experimental or investigational are not covered.

(37) Home and community-based waiver services for intellectually disabled members who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).

(38) Case Management services for the chronically and/or severely mentally ill.

(39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.

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

(41) Early Intervention services for children ages 0-3.

(42) Residential Behavior Management in therapeutic foster care setting.

(43) Birthing center services.

(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services.

(45) Home and Community-Based Waiver services 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 in 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.

PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM/CHILD HEALTH SERVICES

317:30-3-65.7. Vision services

(a) At a minimum, vision services include diagnosis and treatment for defects in vision, including eyeglasses once each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal (refer to OAC 317:30-5-2(b)(5) for amount, duration, and scope). Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary. The following schedule outlines the services required for vision services adopted by the OHCA.

(1) Each newborn should have an assessment of the anatomy of the lids, alignment of the eyes and clarity of the ocular
media with particular attention to documenting the presence of a normal red reflex. The history should document either a normal birth or other condition such as prematurity.

(2) Red reflex and external appearance should be repeated and recorded on infants between one and four months of age.

(3) At six months of age, repeat red reflex and external exam and add an evaluation of ocular alignment with a corneal light reflex test.

(4) One screen should occur between nine and 12 months to mirror the six month screening.

(5) One screening from age three to five including alignment and an acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.

(6) Objective visual acuity testing should be provided at ages five through ten, and once during ages 11 through 18. All other years are subjective by history.

(b) Interperiodic vision examinations are allowed at intervals outside the periodicity schedule when a vision condition is suspected.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 45. OPTOMETRISTS

317:30-5-432.1. Corrective lenses and optical supplies
(a) Payment will be made for children for lenses, frames, low vision aids and certain tints when medically necessary including to protect children with monocular vision. Coverage includes one set of lenses and frames per year. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(b) Corrective lenses must be based on medical need. Medical need includes a change in prescription or replacement due to normal lens wear.
(c) SoonerCare provides frames when medically necessary. Frames are expected to last at least one year and must be reusable. If a lens prescription changes, the same frame must be used if possible. Payment for frames includes the dispensing fee.
(d) SoonerCare reimbursement for frames or lenses represents payment in full. No difference can be collected from the patient, family or guardians.
(e) Replacement of or additional lenses and frames are allowed when medically necessary. Prior authorization is not required unless the number of glasses exceeds two per year. However, the provider must always document in the patient record the reason for the replacement or additional eyeglasses. The OHCA or its designated agent will conduct ongoing monitoring of replacement frequencies to ensure
guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.

(f) Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Progressive lenses, trifocals, photochromic lenses and tints for children require prior authorization and medical necessity. Polycarbonate lenses are covered for children when medically necessary. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(g) Progressive lenses, aspheric lenses, tints, coatings and photochromic lenses for adults are not compensable and may be billed to the patient.

(h) Replacement of lenses and frames due to abuse and neglect by the member is not covered.

(i) Bandage contact lenses are a covered benefit for adults and children. Contact lenses for medically necessary treatment of conditions such as aphakia, keratoconus, following keratoplasty, aniseikonia/anisometropia or albinism are a covered benefit for adults and children. Other contact lenses for children require prior authorization and medical necessity.