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Introduction

Notes

SoonerCare is Oklahoma's Medicaid Managed Care program. Oklahoma Medicaid and ***SoonerCare*** covers individuals who qualify through the Temporary Aid to Needy Families (TANF) program, or who are eligible based on age or disability (ABD). Income eligibility now extends to 185% of the poverty level, which includes Oklahoma's working poor who cannot afford private health coverage.

SoonerCare is a partially capitated Managed Care program operating in all of Oklahoma's counties. ***SoonerCare*** covers all Medicaid eligibles residing in the state except those who are:

- dually eligible for Medicare and Medicaid
- in a HMO
- institutionalized in a nursing home or an intermediate care facility for the mentally retarded
- enrolled in a Home and Community-based Waiver
- individuals in state or tribal custody.

SoonerCare was established in October of 1996 and provides Medicaid qualified Oklahomans with primary and preventive health care services. Health care is provided by a Primary Care Provider/Case Manager (PCP/CM) who contracts with the OHCA for a prepaid, capitated per member/per month payment.

Physicians, Advanced Registered Nurse Practitioners and Physician Assistants can contract as PCP/CMs.

Program objectives include:

- Providing ***SoonerCare*** members with a medical home for primary and preventive care services and case management of most health care needs; and

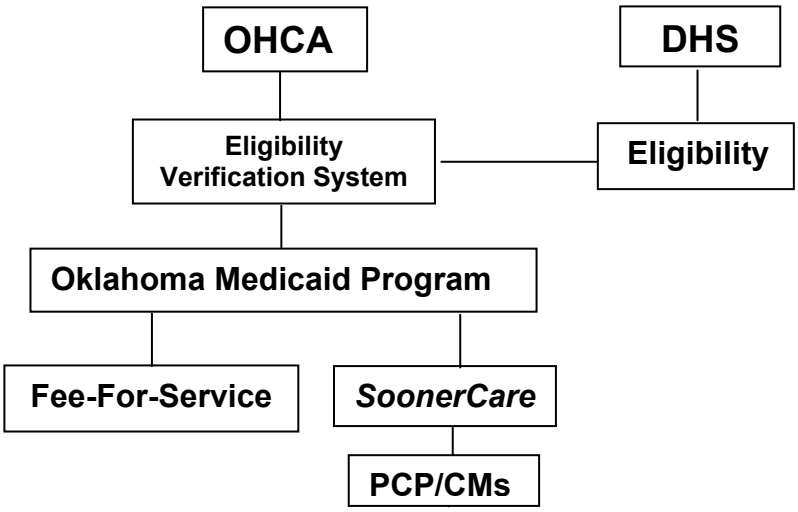
- Instilling a greater degree of budget predictability into the Oklahoma Medicaid program.

Primary Care Providers/Case Managers (PCP/CMs) are paid on a per member/per month basis. Rates are determined based on the age and sex of the member and whether they are eligible through TANF or ABD.

Refer to Attachment C – Capitation Rate Schedule in the "Getting Paid" section.

If compensable services are provided beyond capitated primary care, the PCP/CM is paid for those services based on the Medicaid fee schedule allowables.

Contract Relationships



Quality Assurance

Notes

The Oklahoma Health Care Authority is committed to ensuring the highest quality of access to health care for ***SoonerCare*** members. ***SoonerCare*** providers agree to cooperate with the Authority's external quality of care review organization, internal utilization reviews and other quality assurance efforts.

Quality Assurance Activities

CAHPS Report Card
An annual telephone and mail survey of ***SoonerCare*** members conducted by the Oklahoma Foundation for Medical Quality which measures members' satisfaction with their health care including their PCP/CM.

After-Hours Surveys
Telephone surveys conducted by the Nurse Advice Line after hours to ensure access to medical help as specified in the provider contract.

Member Incident Reports
When a member calls the Helpline with a problem or need, it is documented and reported to the OHCA.

On-Site Audits
Conducted by OHCA Provider Representatives or the Surveillance Utilization Review Subsystem (SURS).

Encounter Data Reviews
Data reflecting rates of utilization of medical care, ER utilization, and referral patterns are pulled from encounter claims and reported to the OHCA.

Access to Care *(Contract Sections 2.3 thru 2.4)*

Notes

Access to care is important. PCP/CMs and office staff need to be familiar with access criteria contained in the ***SoonerCare*** contract.

SoonerCare PCP/CMs are prepaid a capitated amount for each eligible member enrolled with or assigned to them each month.

In return PCP/CMs agree to:

- maintain 24 hour, 7 days per week telephone coverage which will page an on-call medical professional or give information on how members may access medical advice;

- provide each member the information to access 24 hour coverage;

- provide medical evaluation and treatment within 24 hours for urgent medical conditions, e.g., vomiting, diarrhea: Generally, “urgent care is for sudden illnesses or injuries where there is no immediate danger of death or permanent disability;”

- provide routine and non-urgent medical care within three (3) weeks, except for routine physicals and chronic conditions monitored less frequently; and

- provide immunizations and diagnostic tests as medically needed. See Attachment A, Primary Care Capitated Services at end of this section.

Emergency Room

PCP/CMs are not required to provide emergency care in the E.R. If the PCP/CM provides care in the emergency room they will be reimbursed according to the ER case rate. See OHCA 2001-01, January 23, 2001, Dear Medical Provider letter at the end of this section.

The PCP/CM will manage follow-up care as needed.

Emergency Medical Condition – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of **immediate** medical attention could reasonably be expected, by a prudent layperson, to result in:

- Placing the health of the individual (or, with a pregnant woman, the health of her unborn child) in serious jeopardy; or
- Serious impairment to any bodily functions; or
- Serious dysfunction of any bodily organ or part.

PCP/CMs shall not refer members to an emergency room for capitated services for which they are responsible. Providers will interact with members to discourage inappropriate use of the emergency room. See Contract Section 2.4, Emergency Care.

Primary Care

PCP/CMs will provide all capitated medical services for all members who enroll with or are assigned to the PCP/CM and make arrangements for those capitated services they cannot provide directly.

Additional Requirements

PCP/CMs will not exclude members because they are new; will not discriminate; will comply with all State and Federal regulations; cooperate with quality review and utilization review; establish policy and procedures as required.

PCP/CMs will not charge a co-payment for services provided to ***SoonerCare*** members enrolled or assigned to them. See Contract Section 2.2, paragraph H, Contractor responsibilities and Services Provided.

ATTACHMENT A

Medicaid covered services not listed in the capitated benefit section will be reimbursed at the current Medicaid fee-for-service rate subject to all current benefit limitations and prior authorization guidelines.

PCP/CM
Primary Care Capitated Services

OFFICE VISIT - NEW PATIENT

CPT Code	Description
99201	Office and other outpatient medical service, new patient; brief service
99202	Office and other outpatient medical service, new patient; limited service
99203	Office and other outpatient medical service, new patient; intermediate service
99204	Office and other outpatient medical service, new patient; extended service
99205	Office and other outpatient medical service, new patient; comprehensive service

OFFICE VISIT - ESTABLISHED PATIENT

CPT Code	Description
99211	Office and other outpatient medical service, established patient; minimal service
99212	Office and other outpatient medical service, established patient; brief service
99213	Office and other outpatient medical service, established patient; limited service
99214	Office and other outpatient medical service, established patient; intermediate service
99215	Office and other outpatient medical service, established patient; extended service

NEW PATIENT - PREVENTIVE MEDICINE

CPT Code	Description
99381	Office and other outpatient medical service, initial preventive medicine evaluation and management, infant
99382	early childhood, age 1-4
99383	late childhood, age 5-11
99384	adolescent, age 12-17
99385	18-39 years
99386	40-64 years
99387	65 years and over

ESTABLISHED PATIENT - PREVENTIVE MEDICINE

CPT Code	Description
99391	Periodic preventive medicine re-evaluation and management of an individual, infant
99392	early childhood, age 1-4
99393	late childhood, age 5-11
99394	adolescent, age 12-17
99395	18-39 years
99396	40-64 years
99397	65 years and over

EPSDT

CPT Code	Description
W3003	Administration of injections (other than chemotherapy)

Attachment A
Page 2

THERAPEUTIC OR DIAGNOSTIC INJECTIONS

CPT Code	Description
90782	Therapeutic or diagnostic injection (specify material injected); subcutaneous or intramuscular
90788	Intramuscular injection of antibiotic (specify)

IMMUNIZATIONS/INJECTIONS

CPT Code	Description
90471	Immunization administration fee (this code is used if vaccine is obtained through the Vaccines for Children Program)
90472	Immunization administration fee (this code is used if vaccine is obtained through the Vaccines for Children Program)
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633	Hepatitis A vaccine, pediatric/adolescent dosage – 2 dose schedule, for intramuscular use
90634	Hepatitis A vaccine, pediatric/adolescent dosage – 3 dose schedule, for intramuscular use
90645	Hemophilus influenza b vaccine (Hib) HbOC conjugate (4 dose schedule), for intramuscular use
90646	Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
90647	Hemophilus influenza b vaccine (Hib), PRP conjugate (3 dose schedule), for intramuscular use
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
90657	Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use
90658	Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use
90660	Influenza virus vaccine, live, for intranasal use
90669	Pneumoccoccal conjugate vaccine, polyvalent, for intramuscular use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for intramuscular use
90701	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP), for intramuscular use
90702	Diphtheria and tetanus toxoids (DT) absorbed for pediatric use, for intramuscular use
90703	Tetanus toxoid absorbed, for intramuscular or jet injection use
90704	Mumps virus vaccine, live, for subcutaneous or jet injection use
90705	Measles virus vaccine, live, for subcutaneous or jet injection use
90706	Rubella virus vaccine, live, for subcutaneous or jet injection use
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous or jet injection use
90708	Measles and rubella virus vaccine, live, for subcutaneous or jet injection use
90709	Rubella and mumps virus vaccine, live, for subcutaneous use
90710	Measles, mumps, rubella and varicella vaccine (MMRV), live for subcutaneous use
90712	Poliovirus vaccine, (any types) (OPV), live, for oral use
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous use
90716	Varicella virus, vaccine, live, for subcutaneous use
90718	Tetanus and diphtheria toxoids absorbed for adult use (Td), for intramuscular or jet injection
90719	Diphtheria toxoid, for intramuscular use
90720	Diphtheria, tetanus and pertussis (DTP) and Hemophilus influenza B (HIB) vaccine
90721	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTaP-Hib), for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use
90744	Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use
90745	Hepatitis B vaccine, adolescent/high risk infant dosage, for intramuscular use
90746	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, for intramuscular use
90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use

IMMUNOLOGY

CPT Code	Description
86317	Immunoassay for infectious agent antibody, quantitative, not elsewhere specified
86318	Immunoassay for infectious agent antibody, quantitative or semi-quantitative, single step method (e.g., reagent strip)
86403	Particle agglutination; screen, each antibody
86485	Skin test; candida
86580	Tuberculosis, intradermal
86585	Tuberculosis, tine test

Attachment A
Page 3

URINALYSIS

CPT Code	Description
81000	Urinalysis by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrate, pH, protein, specific gravity, urobilinogen, any number of these constituents; with microscopy
81002	Without microscopy, non-automated
81025	Urine pregnancy test

CHEMISTRY

CPT Code	Description
80048	Basic metabolic panel: This panel must include the following; Carbon Dioxide, Chloride, Creatinine, Glucose, Potassium, Sodium, and Urea Nitrogen
82247	Bilirubin; total
82270	Blood, occult, feces screening, 1-3 simultaneous determinations
82947	Glucose, quantitative

HEMATOLOGY AND COAGULATION

CPT Code	Description
85007	Blood count, manual differential WBC count (includes RBC morphology and platelet estimation)
85013	Spun microhematocrit
85014	Other than spun hematocrit
85021	Hemogram, automated (RBC, WBC, Hgb, Hct and indices only)
85022	Hemogram, automated, and manual differential WBC count (CBC)
85023	Hemogram and platelet count, automated, and manual differential WBC count (CBC)
85024	Hemogram and platelet count, automated, and automated partial differential WBC count (CBC)
85025	Hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
85027	Hemogram and platelet count, automated
85031	Blood count, hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices)
85048	White blood cell (WBC)

MICROBIOLOGY

CPT Code	Description
87070	Culture, bacterial; any other source except urine, blood or stool, with isolation and presumptive identification of isolates
87081	Culture, presumptive, pathogenic organisms, screening only
87086	Culture, bacterial, urine, quantitative, colony count

ANATOMIC PATHOLOGY

CPT Code	Description
88150	Cytopathology, smears, cervical or vaginal, up to three smears; screening by technician under physician supervision (obtaining the smear); pathologist reading is not within the capitated service package and will be paid separately fee-for-service.

MOLECULAR DIAGNOSTICS

CPT Code	Description
84702	Gonadotropin, chronic (hCG); quantitative
84703	Qualitative

Attachment A
Page 4

RADIOLOGY

CPT Code	Description (Over-reads which are medically necessary are not within the capitated service package and will be paid separately fee-for-service.)
71010	Radiologic examination, chest; single view, frontal
71020	Radiologic examination, chest, 2 views, frontal and lateral
73060	Humerus, minimum of two views
73090	Radiologic examination, forearm, anteroposterior and lateral views
73550	Radiologic examination, femur, anteriorposterior and lateral views
73590	Radiologic examination, tibia and fibula, anteroposterior and lateral views
73070	Radiologic examination, elbow, anteroposterior and lateral views
73100	Radiologic examination, wrist, anteroposterior and lateral views
73120	Radiologic examination, hand; two views
73560	Radiologic examination, knee; anteroposterior and lateral views
73600	Radiologic examination, ankle, anteroposterior and lateral views
73620	Radiologic examination, foot, anteroposterior and lateral views

Alternative codes used to bill for the services listed above may be changed to codes listed in the benefit package. Additional payment will not be generated.

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

FRANK KEATING
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

OHCA 2001-01

January 23, 2001

Dear Medical Provider:

On December 7, 2000, the Oklahoma Health Care Authority Board approved changes to the Medicaid fee-for-service rules concerning emergency department hospital and physician services. These rules have been signed by the Governor and will become effective for services provided on or after February 1, 2001.

These changes will include **all** fee-for-service and ***SoonerCare Choice*** recipients. For those recipients enrolled in a fully capitated HMO (***SoonerCare Plus***), please consult with the individual health plans. These changes for the fee-for-service and ***SoonerCare Choice*** recipients include:

- **Emergency Department Case Rate –** The new global rate for emergency department services is $50.00 for the facility and $25.00 for codes 99281 through 99285 billed by the physician. The facility global rate is all-inclusive. The patient cannot be billed for any service covered by Medicaid.

- **Outpatient Ancillary Services** – Separate payment will not be made for medically necessary out-patient ancillary services provided in connection with the emergency department service including laboratory tests, x-rays, electrocardiograms, etc. The all-inclusive case rate covers **all** services.

- **Outpatient Hospital Services** – Outpatient emergency department hospital services are no longer limited to two visits for adults. Emergency department visits will not count against the adult recipient's two-physician visit per month limit.

Note: The Emergency Department is intended for evaluation and treatment of medically necessary emergency medical conditions. It is not appropriate for providers to refer patients to the Emergency Department for non-emergency conditions. Medical care for non-emergency medical conditions is to be provided in the office setting. In order to encourage appropriate continuity of care we ask all providers to help patients understand proper use of the Emergency Department. The Oklahoma Health Care Authority will monitor the emergency department services for appropriate use by patients and providers.

We are also pleased to announce that the Provider manuals are now available on the OHCA web site. To access this information enter the web site, located at www.ohca.state.ok.us, from the menu select "Provider", click on the "Billings and Claims" option, then click on "Provider Manual". We encourage all providers to avail themselves of the information available on the web site. The provider letters can also be accessed from this site as well as training schedules and a calendar of events of interest to providers.

These rule revisions represent major changes to the Medicaid Program. The revisions are made possible by the Oklahoma 2001 Healthcare Initiative, which was included in House Bill 2019. This is expected to result in better access to healthcare for patients, improved data collection, and a more appropriate payment for the services provided.

If you have any questions concerning these changes, please contact Customer Service at (405) 522-6205 or 1-800-522-0310.

Sincerely,

/s/
Michael Fogarty
Chief Executive Officer

Care Management

Notes

The Oklahoma Medicaid Care Management Department facilitates and coordinates services to ***SoonerCare*** members and fee for service Medicaid clients with complex and/or exceptional heath care needs. This department includes nurse exceptional needs coordinators (ENCs).

Services provided by the Care Management Department include:

- Facilitate and coordinate care for individuals with complex chronic medical conditions such as high risk OB cases and transplant cases;
- Research, assist, and support PCPs and office staff in locating specialty providers;
- Educational intervention for members with
  - Inappropriate ER visits
  - High service utilization
  - Conditions in need of Medical regimen reinforcement
  - Dual medical/behavioral health needs
- Lock-in evaluation for members with
  - Significant prescription histories
  - Multiple providers/pharmacies
  - Frequent ER visits

If you need additional information or assistance from the Medicaid are Management Department, please call

toll free (800) 522-0114, option #3 or
local (405) 522-6205, option #3

Care Management

Notes

Locating Dental Providers

The OHCA contracted fee-for-service dental network, which is organized by county and includes out of state providers, can be accessed through the OHCA website at **www**.ohca.state.ok.us/consumer/enrollment/dentists

You may also contact the OHCA Dental Division to assist you, your office staff, and patients in locating a dentist.

Dental Division: 405-522-7401

Locating Specialty Providers

The Care Management Department can assist and support PCPs and their office staff in locating specialty providers, as well as facilitating appointments.

This assistance includes coordination with the patient and the patient's family, if indicated. In addition, transportation needs can be identified and coordinated.

If you need additional information or assistance from the Medicaid Care Management Department, please call

Statewide Toll-Free **800-522-0114 (Option #3) or**
Oklahoma City Metro Area **405-522-6205 (Option #3).**

Patient Education

The Care Management Department can assist and support PCPs and their office staff in reinforcing specific medical regimens for patients having difficulty managing an acute illness episode, a chronic health condition, or multiple health conditions.

This can include routine or periodic telephone communication with the patient and the PCP's office.

If you need additional information or assistance from the Medicaid Care Management Department, please call

Statewide Toll-Free **800-522-0114 (Option #3) or**
Oklahoma City Metro Area **405-522-6205 (Option #3).**

Member Enrollment *(Contract Sections 3.1 - 3.3)*

Notes

Eligibility and Certification

Individuals become ***SoonerCare*** members because of one or more of the following reasons:

- They are determined to be eligible for Medicaid.
- They qualify for Temporary Assistance to Needy Families (TANF).
- They qualify as Aged, Blind, or Disabled (ABD).
- They live in one of the counties covered by ***SoonerCare***.

Exceptions are individuals who are:

⇒ enrolled in an HMO
⇒ institutionalized
⇒ in state or tribal custody
⇒ enrolled in the home and community based waiver program

Medicaid benefits start when DHS determines eligibility for Medicaid **and certifies** the case. The effective date of ***SoonerCare*** benefits depend on the certification date. Always check the Eligibility Verification System (EVS) either by calling the toll free EVS line or through the swipe card, PC option or internet.

> **NOTE:** Medical care during the time a client is eligible for Medicaid, but not yet effective in ***SoonerCare,*** will be covered under the Medicaid fee-for-service program.

Continuing eligibility for Medicaid benefits must be re-certified periodically. The re-certification intervals vary according to the type of assistance members are receiving. Medicaid recipients are notified in writing by

DHS prior to the expiration of benefits. See the sample letter at the end of this section.

Breaks in eligibility may mean a disruption in continuity of care. If the PCP/CM's capacity is limited in comparison to demand the member may not be able to regain his/her place on that PCP/CM's panel.

Members may reenroll with a PCP/CM by calling the ***SoonerCare*** Helpline if they have a break in eligibility and are being recertified. Members who lose and regain eligibility with 180 days are assigned to their most recent PCP/CM if that PCP/CM has available capacity..

Choosing a PCP/CM

The OHCA offers all members the opportunity to choose a PCP/CM from the provider directory. If a member does not choose a PCP/CM, the OHCA will assign the member to a PCP/CM.

Families with more than one eligible member are allowed to choose a different PCP/CM for each eligible member.

Enrollment with a PCP/CM takes effect at the beginning of each month. The OHCA provides the PCP/CM with his or her new enrollees, continuing members, and terminated members on a new ***SoonerCare*** Monthly PMP Enrollment Roster prior to the first day of each month.

Capacity (Number of Members requested per PCP/CM)

The PCP/CM specifies the maximum number of members he/she is willing to accept. Under the terms of the contract the minimum number is 150 for an individual PCP/CM and the maximum number is 2500 for each Physician PCP/CM. The maximum capacity for Physician Assistants and Nurse Practitioners serving as PCP/CMs is 1250 members.

If a PCP/CM is part of a PCP/CM/group the minimum number is 200 and the maximum number is 2500 per provider in the group.

OHCA cannot guarantee the number of members a PCP/CM receives.

A PCP/CM may request a change in his/her capacity by submitting a written request to the ***SoonerCare*** Division of the OHCA. If approved, the OHCA will implement the change on the first day of a month with sufficient notice.

If a PCP/CM requests a lower capacity, within program standards, and it is approved by the OHCA, the reduction in numbers of members will be accomplished through attrition as members change PCP/CMs or lose eligibility.

Members will **not** be disenrolled to achieve a lower capacity.

Changing PCP/CMs

The OHCA may change a recipient from one PCP/CM to another PCP/CM:

1. without cause up to 4 times per year upon the **member's request**; or

2. when a PCP/CM terminates his or her participation in the ***SoonerCare*** program.

See the ***SoonerCare*** Provider Change Request Action Form at the end of this section.

Disenrollment At The Request of the PCP/CM

(Contract Section 4.2)

A PCP/CM may file a written request that the OHCA take action including, but not limited to, disenrolling a member when the member is physically or verbally abusive (threatening) to office staff, providers and/or other patients or the member is "habitually non-compliant," i.e. regularly fails to arrive for scheduled appointments without canceling, and in either instance the PCP/CM has made all reasonable efforts to accommodate the member.

The PCP/CM must document all efforts to inform the member, both orally and in writing, of any actions that have interfered with the effective provision of covered services, as well as explain the following:

1. What actions or language of the member are acceptable and what is unacceptable;
2. The consequences of such continued behavior, including the PCP/CM filing a request to seek disenrollment; and
3. The potential disenrollment from the PCP/CM program and placement in the FFS program.

In all instances, the PCP/CM must seek member disenrollment through filing a written request to the Authority directed to the ***SoonerCare*** Director. The request must include comprehensive documentation describing the difficulty encountered with the member (i.e. nature, extent and frequency of abusive or harmful behavior, violence, and/or inability to treat or engage enrollee), identification and documentation of unique religious or cultural issues that may be affecting the PCP/CM's ability to provide treatment effectively to the member, as well as documentation of special assistance or intervention offered.

The PCP/CM must give written notice of the disenrollment request to the member and must advise the member of the request to the OHCA for review. This notice must include

the mailing address and the telephone number of the Authority. The PCP/CM must also provide the Authority with any documentation filed by the member in response to the notice of intent to disenroll.

In the event the disenrollment request is approved, the member will be disenrolled from the ***SoonerCare*** program and enrolled into the FFS program through the end of the contract year to ensure continuity of care, unless another PCP/CM within the distance standard agrees to accept the member for enrollment to ensure continuity of care. In this instance, the Authority will provide notices to the Contractor as well as the member.

The member will not be enrolled with the same PCP/CM again, unless the PCP/CM agrees to the enrollment in writing.

Either party has the right to appeal the decision to the Administrative Law Judge pursuant to OAC 317:2-1-2 (the Authority's Grievance Procedure).

OKLAHOMA COUNTY DHS
2409 N. KELLEY AVE.
P.O.BOX 26768
OKLAHOMA CITY, OK 73126

OFFICE CODE C
PHONE # (405) 522-5818
1-800-884-1534

DATE 03/18/2002

CLIENT NAME
1234 NW. MAIN STR.

OKLA CITY OK 73117-8410

CASE NO. C123456
DIST. 00 SUPVR. 00

NOTICE OF EXPIRATION OF MEDICAL ELIGIBILITY

YOUR ELIGIBILITY FOR MEDICAL ASSISTANCE (SOONERCARE) MAY EXPIRE EFFECTIVE 05.01.2002 UNLESS YOUR ELIGIBILITY CAN BE REDETERMINED.

FOR YOUR CONVENIENCE, A RE-CERTIFICATION FORM FOR MEDICAL ASSISTANCE IS ENCLOSED. ALL QUESTIONS ON THE FORM MUST BE COMPLETED WITH CURRENT INFORMATION ABOUT YOUR HOUSEHOLD. TO AVOID INTERRUPTION IN YOUR SOONERCARE SERVICES. PLEASE RETURN THE FORM TO YOUR LOCAL DHS OFFICE NO LATER THAN 05/01/2002.

THE RECERTIFICATION FORM WILL BE ACCEPTED AS LONG AS IT HAS A READABLE NAME AND ADDRESS. IF YOU NEED HELP IN COMPLETING THE FORM, PLEASE CONTACT THE LOCAL DHS OFFICE FOR ASSISTANCE. THE ADDRESS AND PHONE NUMBER IS SHOWN AT THE TOP OF THIS LETTER. PLEASE COMPLETE THE RE-DETERMINATION FORM (FSS-BR1-MED) AND MAIL IT OR TAKE IT TO YOUR LOCAL DHS COUNTY OFFICE.

HEALTH BENEFITS REVIEW REPORT

Department of Human Services

Office code:	
Phone number:	
Case number:	
District:	
Supervisor:	

The information you report on this form is used to see if your household is still eligible for Health Benefits. Please complete, sign, and return this form and the required proof as quickly as possible to the DHS office listed above. If you need help completing the form, call your DHS office and ask for help.

RETURN THIS FORM BY _____ **OR YOUR BENEFITS WILL STOP ON** _____ .

COMPLETE THIS SECTION. If you have moved or the address shown is not current, complete the information below.

Street or rural route or P.O. Box	Apartment or lot number		
City	State	Zip	New telephone number

If your finding address is different from your mailing address, please give directions to your home:

_____

_____

Listed below are the people previously reported living in your household and benefits received. Indicate which persons are still in your household.

Name	Benefit	Benefit	Benefit	Benefit	Still in household? Circle yes or no
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No

Does anyone else live at this address? Circle Yes No If yes, complete below:

Name	Social Security no.	DOB	Citizenship	Relationship to you

REPORT ALL INCOME FROM WORK HERE. Provide information below about each person in your household who works.

YOU MUST SEND PROOF OF ALL EARNED INCOME RECEIVED BY PEOPLE IN YOUR HOUSEHOLD. You may send:

- a check stub for each pay check received in the most recent full calendar month;
- a statement from the employer showing pay dates and gross earnings (before taxes) received in the prior calendar month; or
- if you are self-employed provide your federal income tax return for the previous year or your records of income and expenses if taxes have not been filed.

Employment. List name of person working, employer's name, and work phone number.

Name		Employer
Gross income (before taxes)	How often paid?	Work phone number
Name		Employer
Gross income (before taxes)	How often paid?	Work phone number
Name		Employer
Gross income (before taxes)	How often paid?	Work phone number

Self-employed earned income.

Enter gross income for the latest year	Total business expenses, such as supplies or gasoline

Terminated income in the last five months. If anyone has stopped working, please complete below:

Person's name	Date of final check	Amount of final check

Please provide proof of this information such as the final pay check stub, and an employer statement showing termination information.

REPORT ALL UNEARNED INCOME HERE. List all checks or money currently received by you or any other household member. **Examples:** Social Security, SSI, TANF, Tribal TANF, VA, unemployment benefits, worker's compensation, child support, military allotments, contributions, interest, dividends, pension, student grants and loans, rental income, mineral rights, or oil and gas leases.

Name of person who gets this income	Amount of income	How often received?
Source of this income (list agency or person)		
Name of person who gets this income	Amount of income	How often received?
Source of this income (list agency or person)		
Name of person who gets this income	Amount of income	How often received?
Source of this income (list agency or person)		

We can accept as proof an award letter or other correspondence from the person or agency who provides the income. We may also be able to accept other proof which shows your current income.

If the unearned income of any household member ended in the last **five** months, complete below:

Name	Income that stopped

Child support.

Does anyone in your household pay court-ordered child support? Circle Yes No

If yes, who pays?		To whom?		
Address	City	State	Zip	Telephone number
How much?		How often?		

Please provide proof of the current court order and verification of the regular child support payments being paid.

Resources. Complete only for food stamps and health benefits. **We will need proof of current value of all resources.**

Circle all of the following resources your household has: checking accounts
savings accounts land trust funds mineral rights
stocks bonds Individual Retirement Accounts (IRAs)
☐ other: _____

Report all vehicles here. List all cars, trucks, boats, vans, campers, and motorcycles or other licensed vehicles owned by household members.

Make	Model	Year	Loan balance
Make	Model	Year	Loan balance

HEALTH BENEFITS.

Is any member listed in Section I requesting Health Benefits for pregnancy? Circle Yes No

If yes, who?	Expected delivery date

Attach written medical proof of pregnancy If available.

Health/dental insurance. Is anyone in the household covered by health or dental insurance? Circle Yes No If yes, complete the following:

Who is covered?	Type of insurance	Name of insurance company	Effective date
Address of insurance company	City	State	Zip
Policy holder's name	Policy holder's Social Security number	Relationship to insured	

Health and dental screening. Individuals under age 21 eligible for Health Benefits are eligible for health and dental screening examinations and follow-up treatment under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Are you interested in the screening examinations? Circle Yes No

Parental support. Does any child have a parent who is not living in the home? Circle Yes No
If yes, please complete below:

Child's name	Absent parent's name
Child's name	Absent parent's name

Attach proof of your current work/school/training schedule to this form.

OTHER.

The following programs are available through DHS: food stamps, child care, cash assistance, Health Benefits, and child support. Please contact your worker if you need further information about these programs.

I understand failure to complete and return this form with attached proof could result in closure of benefits. I agree to provide the proof necessary to establish continued eligibility.

My answers on this form are true, correct and complete to the best of my knowledge. I understand my Rights and Responsibilities, Penalty Warnings and Release of Information from my last application apply to this review.

Signature of client, guardian, conservator, or authorized representative _____ Date _____

Use when client cannot read or write or signs by mark.

Signature of witness _____ Date _____

Referrals

Notes

SoonerCare referrals:

- are made on the basis of **medical necessity** as determined by the PCP/CM
- are required for **all inpatient hospital** services except OB delivery
- are required **prior** to receiving the referred service. Referrals for inpatient admissions from an emergency room may be obtained in a reasonable period following the admission.
- must have the correct provider referral number to insure payment to the "referred to" provider (provider/referral numbers are site specific)

Referrals must be signed by the PCP/CM or a designee within the PCP/CM's office who is authorized to sign for the provider.

Some services **may also** require prior authorization. It is up to the "referred to" provider, or provider ordering services, to obtain prior authorization as needed. Prior authorizations for services are obtained through the Medical Authorization Unit at OHCA.

SoonerCare referrals **must be made**:

- if the member requests a second opinion, further treatment related to the second opinion must be authorizedthrough a referral made by the PCP/CM.

SoonerCare referrals **may**:

- be made to another PCP/CM for services equal to those of a specialist

  Examples:
  - ✓ A PCP/CM Family Practitioner who performs a surgical procedure
  - ✓ A PCP/CM Internist who manages complicated diabetic members

SoonerCare referrals **may:**

- be made to a provider for ongoing treatment for a period of time specified by the PCP/CM, but limited to 12 months. For the duration of the referral, the "referred to" provider will not be required to receive further referrals to provide treatment for the specific illness indicated on the referral.

SoonerCare referrals are **not** required for:

- child physical / sexual abuse exams
- services provided by a PCP/CM for members enrolled or assigned to the PCP/CM
- emergency room visits
- obstetrical care
- vision screenings for members under 21
- basic dental for members under 21.
- behavioral / mental health
- family planning for members under 18
- services provided to Native Americans in a tribal, IHS, or Urban Indian Clinic facility

Inappropriate Referrals

Referrals should not be written for capitated services that are within the provider's field of expertise or scope of practice. Federal regulations prohibit OHCA from paying twice for the same service.

Payment of Referred Services

- Payment for referred services is subject to coverage limitations under the current Medicaid reimbursement policies.

- Payment for referred services is limited to two (4) specialty visits per month for adults over age 21 whether self-referred or PCP/CM-referred. OB visits are excluded from this limitation.

- PCP/CMs must refer only to Medicaid providers who have an active Medicaid FFS contract to insure payment.

Documenting the Medical File

- Documentation in the medical record should include a copy of each referral to another health care provider and any additional referrals made by the "referred to" provider when this information is known, e.g. ancillary services.

- Documentation in the medical record should include a medical report from the provider to whom the referral was made. The "referred to" provider should report his findings to the referring PCP/CM within two weeks after the member's appointment. In the event a medical report is not received within a reasonable amount of time the PCP/CM should contact the health care provider to whom the referral was made.

Unauthorized Use of a Provider's Number

Unauthorized use of a ***SoonerCare*** provider's number may result in official action to recover unauthorized reimbursements from the billing provider.

Referral Form and Instructions

In the ***SoonerCare*** program, the PCP/CM is responsible for providing primary care and making specialty referrals.

- The PCP/CM completes the referral form including the referral number. The PCP/CM's ***SoonerCare*** provider number serves as their referral number. The provider/referral number is site specific and must be for the site at which the member is enrolled or assigned.

- The referral includes ancillary services rendered, or required, by the "referred to" specialist.

With the PCP/CM's approval, a specialist may relay a copy of the original referral to other specialists with instructions considered necessary for proper treatment of the member. Payment is subject to the current Medicaid reimbursement policies.

Upon completion the form is distributed as follows:

1. The provider mails the original of the form to the specialist, or "referred to" provider.

2. A copy of the form is retained in the patient's medical record.

When a claim is submitted by a "referred to" provider, the referral number must be entered in box 17a of the HCFA 1500 claim form, or box 83b of the UB92 hospital claim form. A copy of referral is **NOT** attached to the claim. If the referral number is not on the claim form, payment will be denied unless for self-referred services.

Providers with multiple sites must use the referral number for the site at which the member is assigned.

Referral forms can be accessed and printed from the OHCA website.

If you are unable to access the Internet, referral forms may be obtained by calling the EDS Supply Line.

State of Oklahoma
Oklahoma Health Care Authority

SoonerCare Choice Referral Form
Oklahoma's Managed Care Medicaid Program

Please Print

Client Name

Last Name | First Name | Middle Initial

Client ID# (nine digits)

Client Phone

Referred to:

Provider Name (Must be a current Medicaid provider)

Provider Phone

Provider Address

PCP/CM Referral Valid for (check one)

☐ Initial Visit Only

☐ Evaluation & Treatment for _____ months (cannot exceed 12 months)

Diagnosis (Use ICD-9 Codes)	1.	2.	3.

Reason for Referral:

Referred by:

Primary Care Provider/ Case Manager Name

PCP/CM Phone

Signature of Referring Provider

Date

PCP/CM # Referral Number (ten digits)

- This referral is valid for all ancillary services related to the above diagnosis within the specified time frame.
- This referral may be forwarded to other specialists for the above diagnosis with the approval of the PCP/CM.
- Report your findings directly to the provider who made this referral.
- This referral number should be entered by the referred to provider in Block 17a of the HFCA 1500 claim form or Block 83b of the UB 92 claim form.
- This form is for referral only. It does not replace the prior authorization form. Some services for ***SoonerCare*** clients require (1) PCP/CM referral **and** (2) prior authorization from the Medical Authorization Unit at Oklahoma Health Care Authority. The current prior authorization policies are unchanged (See Oklahoma Health Care Authority Rules).
- All payments for services are subject to coverage limitations under the current Medicaid program and the referral is not a guarantee of payment.

Instructions:

1. Complete and mail the original copy of this form to the provider to whom you are referring.
2. Keep a duplicate copy for your records in the client's medical chart.
3. Referral form (SC-10) may be obtained on the OHCA web site at http://www.ohca.state.ok.us/provider/billing/forms

PLEASE DO NOT MAIL OR FAX A COPY TO OHCA.
PLEASE DO NOT ATTACH A COPY TO YOUR CLAIM FORM.

Administrative Guidelines for *SoonerCare* Referrals

1. All payments for referred services are subject to coverage limitations under the current Medicaid program.

2. Referrals do not replace the prior authorization process through OHCA. The current prior authorization policies regarding Medicaid covered services are unchanged. Services that require a prior authorization from OHCA will need both a referral and an prior authorization.

3. Services provided by a PCP/CM for recipients enrolled with that PCP/CM do not require a referral.

4. When the PCP/CM is unable to provide a Medicaid covered service (and the service is not listed as a self-referred service) the PCP/CM should refer the recipient to another provider who can provide the appropriate specialty care. The provider of the specialty care must be a Medicaid provider.

5. A PCP/CM referral is necessary **prior** to the recipient's visit for the referred services.

6. When care is provided in the emergency room, no PCP/CM referral is necessary for the ER visit. However, some additional procedures done by the provider in the ER may require a referral. A PCP/CM referral will be necessary if patient is admitted to the hospital from the emergency room. A referral from the PCP/CM may also be necessary for follow-up care if the PCP/CM is not providing the follow-up care.

7. **ALL** inpatient hospital admissions require a referral from the PCP/CM except for admissions for OB delivery.

8. Referral from one PCP/CM to another provider who also serves as a PCP/CM is allowed if the PCP/CM who is the "referred to " provider can provide services equal to those available through a specialist. Two examples are: (1) a Family Practitioner could refer to another Family Practitioner who performs a surgical procedure. (2) a General Practitioner could refer to an Internist who manages complicated diabetic patients.

9. The PCP/CM is responsible for making all referrals. Nurse Practitioners and Physician Assistants may not directly authorize a referral unless the Nurse Practitioner or Physician's Assistant has a contract with OHCA to serve as the patient's PCP/CM. However, Nurse Practitioners and Physician Assistants may facilitate the referral process for the PCP/CM with whom they collaborate.

10. The PCP/CM referral number **must** be on all referral forms. OHCA will not reimburse the provider unless the PCP/CM's referral number is on the claim form. The referral number must be in box 17a on the HCFA 1500 form and box 83b on the UB 92 form.

11. PCP/CMs with multiple sites should ensure that the proper referral number is used. This number is the site to which the patient is enrolled/assigned.

12. The referral includes ancillary services rendered by a specialist; however, for billing purposes the specialist and provider of any related services must obtain and enter the PCP/CM's referral number on the Medicaid claim(s).

13. With the PCP/CM's approval, his/her number may be relayed by a specialist to other specialists with instructions considered necessary for proper treatment of the patient within the current Medicaid benefit structure.

14. At the PCP/CM's discretion, a referral may be made to a specialist for ongoing treatment of a specific illness for
    a period of time specified by the PCP/CM up to twelve months. For the duration of the referral, the specialist will not be required to receive further referrals to provide treatment for the specific illness indicated on the referral.

15. All referred visits (self-referred and PCP/CM-referred) for adults are limited to two (2) visits per month.

16. Referrals for specialty care for a specific illness or condition can be made for up to a year by the PCP/CM. However, the referral must be renewed after a year. **Eligibility should be verified upon each visit to ensure that the referral has not been voided by loss of eligibility.**

17. A referral must be made if the recipient requests a second medical opinion. After the second opinion has been obtained, any treatment received by the recipient is to be rendered by the PCP/CM or through a referral made by the PCP/CM.

18. Documentation in the medical record should include a copy of each referral to another health care provider and any additional referrals made by the "referred to " provider when this information is known.

19. Documentation in the medical record should include a medical report from the provider to whom the referral was made. The" referred to" provider should report his findings to the referring provider within two weeks after the patient's appointment. In the event a medical report is not received within a reasonable amount of time the PCP/CM should contact the health care provider to whom the referral was made.

20. The PCP/CM should educate recipients regarding those services which are available to recipients under the ***SoonerCare*** program which do not require a referral from the PCP/CM.

21. Self-Referral services or services that do not require a referral from the PCP/CM are:

Basic dental care if under age 21	Basic vision care services if under age 21
True emergency care	Pharmacy
Family planning services for adolescents under age 18	OB services
Mental health and substance abuse services	Child sexual abuse exams

Services provided to Native Americans in an IHS/Tribal/Urban Indian Clinic

OHCA reserves the right to unilaterally change this list of services upon written notice to PCP/CMs of such changes subject to the benefit limitations of the Medicaid program.

22. Unauthorized use of a ***SoonerCare*** provider's referral number will result in official action to recover unauthorized reimbursements from the billing physician.

Instructions for Completion of the Referral Form

In the ***SoonerCare*** program, the Primary Care Physician/Case Manager (PCP/CM) will be responsible for providing primary care and making specialty referrals. The procedure to be used for this referral process is detailed below.

The PCP/CM will complete the referral form, including the PCP/CM's ***SoonerCare*** referral number. Upon completion the form will be distributed as follows:

1. The provider will mail or fax the original of the form to the specialist, or "referred to" provider.
2. A duplicate copy is to be kept in the patient's medical record.
3. **Do not send a copy to EDS.**
4. **Do not send o copy to OHCA.**

When a claim is submitted for non-primary care services or services other than self-referral services, the referral number must be entered in the appropriate field on the claim form unless the provider is the PCP/CM. If the referral number is not on the claim form, payment will be denied.

Referral forms may be obtained by calling the OHCA Supply Line at **(405) 522-7375 or the OHCA web site at www.ohca.state.ok.us.**

SoonerCare Choice Referral Form
Oklahoma's Managed Care Medicaid Program

Please Print

Recipient's Name: **Doe** (Last Name) **John** (First Name) **A** (Middle Initial)

Recipient ID# (Case # including person code): **012345678**

Recipient Phone: **(460) 360-1234**

Referred to:

Provider Name (Must be a Medicaid provider): **Joe B. Good**

Provider Phone: **(405)761-1234**

Provider Address: **123 University Center** **Anywhere, OK 73000-0000**

PCP/CM Referral Valid for (check one): ☑ Initial Visit Only ☐ Evaluation & Treatment for _____ months (cannot exceed 12 months)

Diagnosis (Use ICD 9 Codes)	1. **433.1**	2.	3.

Reason for Referral: This person is sick.

Referred by:

Primary Care Provider/ Case Manager Name: **Dr. Bewell**

PCP/CM Phone: **(405) 321-1234**

Signature of Referring Provider: Dr. Bewell MD

Date: **04/09/2003**

PCP/ CM # Referral Number (must be eleven digits): **123456789B**

- This referral is valid for all ancillary services related to the above diagnosis within the specified time frame.
- This referral may be forwarded to other specialists for the above diagnosis with the approval of the PCP/CM.
- Report your findings directly to the Provider who made this referral.
- This referral number should be entered by the referred to Provider in Block 11 of the UB 92 claim form or Block 17a of the HFCA 1500 claim form.
- This form is for referral only. It does not replace the prior authorization form. Some services for ***SoonerCare*** recipients require (1) PCP/CM referral **and** (2) prior authorization from the Medical Authorization Unit at Oklahoma Health Care Authority. The current prior authorization policies are unchanged (See Provider Manual).
- All payments for services are subject to coverage limitations under the current Medicaid program and is not a guarantee of payment.

Instructions:

1. Complete and mail the original copy of this form to the provider to whom you are referring.
2. Keep a duplicate copy for your records in the recipient's medical chart.
3. To reorder this form please call (405) 522-7375.

PLEASE DO NOT FAX A COPY TO OHCA
PLEASE DO NOT ATTACH A COPY TO YOUR CLAIM FORM.

EPSDT

(Contract Section 2.5)

Notes

EPSDT stands for **E**arly and **P**eriodic **S**creening **D**iagnosis and **T**reatment.

EPSDT is a federally mandated program and is one of the highest priorities of the Oklahoma Medicaid Program and ***SoonerCare***.

EPSDT is designed to provide a comprehensive program of preventive screening examinations, dental, vision, hearing, and immunization services to ***SoonerCare*** members under the age of 21.

Schedule of EPSDT Services

As a minimum the following schedule for EPSDT screening is required:

- Six (6) visits during the first year of life;
- Two (2) visits in the second year of life;
- One (1) visit yearly for ages two through five;
- One (1) visit every other year for ages six through twenty
- Metabolic lead screen by age 2 or 72 months if not done by age 2. This is mandatory

Additional Requirements

In addition, the OHCA requires that contractors shall:

- Conduct and document follow-up with all members under 21 who miss appointments;
- Outreach, including telephone calls or printed notification mailed to a member when a health-care screen is indicated or missed, to ensure that all members under 21 are current; and
- Educate families of members under 21 about the importance of early periodic screening, diagnosis and treatment.

EPSDT Bonus Payment

OHCA offers incentive bonuses to be paid to PCP/CMs who demonstrate a specified screening rate.

To qualify for the EPSDT bonus, verifiable encounter claim data must be submitted in a timely manner as set forth in Contract Section 5.6. OHCA may conduct onsite chart audits.

See “Getting Paid” for further bonus payment details.

Getting Paid

Notes

Capitation Payments
(Contract 2002, 2003 & 2004 - Attachment C)

SoonerCare PCP/CMs are prepaid for each member assigned or enrolled with them on a monthly basis (Capitation Payments).

Capitation payments vary with the member's age, gender and benefit type (TANF or ABD). Case management fees are paid in addition to the benefit payment and some are enhanced. See Attachment C, end of this section.

Capitation payments are made by the 10th working day of each month for all eligible members enrolled with or assigned to the PCP/CM on the first of each month. A single monthly payment is generated and accompanies the capitation payment listing or is deposited directly.

Encounter Claims *(Contract Sections 2.2 B., 2.7A.)*

Although ***SoonerCare*** PCP/CMs are paid in advance for primary care services, PCP/CMs are **required** to file a claim with the OHCA each time a service is provided to a member. Claims filed for a prepaid service are called Encounter Claims. Services that are not capitated should be filed on the same claim and will be paid subject to the current Medicaid fee schedule and reimbursement policies.

Encounter Claims are to be submitted within **45 days** of the date the service is provided on a HCFA 1500 claim form.

Encounter claims are verification of the services you provide to ***SoonerCare*** members. See HCFA 1500 form and instructions at the end of this section.

EPSDT Bonus Payment (*Contract Section 5.6)*

Because of the high priority placed on Early and Periodic Screening Diagnosis and Treatment (EPSDT) services, the PCP/CM may qualify for and receive a bonus payment if the PCP/CM:

- achieves a certain compliance level for EPSDT screens during the contract year. See contract amendments for current year compliance level.
- meets, performs and documents with timely filed Encounter Claims all required EPSDT standards and services. See ***SoonerCare*** Monthly PMP Enrollment Roster for last screening date.
- provides medically necessary follow-up
- demonstrates that he/she has outreach mechanisms in place to encourage members to obtain appropriate screenings. See the services schedule in the EPSDT section.

The Authority shall make this additional payment in a lump sum within one hundred fifty (150) days after the end of the contract year. Actual compliance rate will be based upon encounter data submitted no later than February 1st of each year.

Stop-Loss for TANF Members *(Contract Section 5.13)*

To limit risk to PCP/CMs, a threshold of $1800 per year in capitated services ($450 per quarter) is established by the stop-loss for members eligible through Temporary Assistance to Needy Families (TANF). This is based on the Medicaid Fee Schedule allowables, not gross charges.

PCP/CMs who have members they feel have met their stop-loss should contact their Provider Representative. See Contract Section 5.13.

ABD Member Bridge Payment *(Contract Section 5.11)*

For ***SoonerCare*** members categorized as the Aged, Blind and Disabled (ABD), the OHCA will make supplemental payments on a quarterly basis to providers whose utilization by these members (based on fee schedule equivalent reimbursement) exceeds the capitation paid (less case management) for the same period. Provision of services to ABD members must be verifiable by timely filed Encounter Claims. (See Contract Section 5.11, paragraph A)

SoonerCare Contract Section 5.12 outlines the recoupment of this money paid if total yearly utilization falls below the total capitation paid for the year.

For each Contract Year all clean encounter claims submitted by February 28 of the following year will be considered in the final contract year bridge payment.

Immunization Incentive Payment
(Contract Section 5.9)

Immunization Incentive Payments are available when the PCP/CM provides written notice that he/she has administered the 4th dose of DPT/DTAP to a member before the member's second birthday. The OHCA will process the incentive payments twice per year. The review periods are January 1 through June 30 and July 1 through December 31. For details see Contract Section 5.9.

Enhanced Payment for SP/ABD or SP/TANF Case Management *(Contract Section 5.4)*

In addition to the monthly capitation rate, PCP/CM's will be paid an additional $3.00 per month for each SP/ABD and SP/TANF member enrolled with the PCP/CM. Payments are disbursed on a quarterly basis. For details see Contract Section 5.4.

ATTACHMENT C
Monthly Capitation Rate Schedule
Effective for 2002, 2003 & 2004

TANF Members

Rate Category	Age	Base Rate	Case Management	Total Cap. Payment
Male/Female	<1	$ 37.18	$ 3.00	$ 40.18
Male/Female	<2	$ 18.78	$ 3.00	$ 21.78
Male/Female	2 – 5	$ 15.52	$ 2.00	$ 17.52
Male/Female	6 – 14	$ 9.19	$ 2.00	$ 11.19
Female	15 – 20	$ 12.66	$ 2.00	$ 14.66
Male	15 – 20	$ 6.93	$ 2.00	$ 8.93
Female	21 – 44	$ 10.59	$ 2.00	$ 12.59
Male	21 – 44	$ 8.48	$ 2.00	$ 10.48
Male/Female	>44	$ 12.02	$ 2.00	$ 14.02

ABD Members

Rate Category	Age	Base Rate	Case Management	Total Cap. Payment
Male/Female	<1	$ 37.18	$ 3.00	$ 40.18
Male/Female	<2	$ 21.49	$ 3.00	$ 24.49
Male/Female	2 – 5	$ 21.49	$ 3.00	$ 24.49
Male/Female	6 – 14	$ 21.49	$ 3.00	$ 24.49
Female	15 – 20	$ 21.49	$ 3.00	$ 24.49
Male	15 – 20	$ 21.49	$ 3.00	$ 24.49
Female	21 – 44	$ 19.76	$ 3.00	$ 22.76
Male	21 – 44	$ 19.76	$ 3.00	$ 22.76
Male/Female	>44	$ 19.76	$ 3.00	$ 22.76

Please note that these rates will be paid for the capitated services listed in the benefit package. Covered services provided which are not in the capitated benefit package will be paid on the current Medicaid fee-for-service schedule.

Individuals who are dually eligible for Medicare/Medicaid are not part of the program at this time.

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, A. John

3. PATIENT'S BIRTH DATE MM DD YY: 05 23 70 | SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: Anywhere | STATE: OK

8. PATIENT STATUS: Single | Married X | Other

CITY | STATE

ZIP CODE: 73000 | TELEPHONE (Include Area Code): (405) 360-1234

Employed X | Full-Time Student | Part-Time Student

ZIP CODE | TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO — *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File | DATE: 3/1/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 433.1
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	03 01 01	03 01 01	11		99213		1	60.00	1						
2															
3															
4															
5															
6															

25. FEDERAL TAX I.D. NUMBER: 123456789 | SSN X | EIN

26. PATIENT'S ACCOUNT NO.: 0000000111

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X | NO

28. TOTAL CHARGE: $ 60.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 60.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: John Doe MD | DATE: 3/1/01

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

ABC Clinic
123 Ash Street
Anywhere, OK

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# 123456789B | GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — ***PLEASE PRINT OR TYPE*** — FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

HCFA 1500

Data Elements Required for Oklahoma Medicaid Billing

All claims filed on the HCFA 1500 claim form may only be one page long.

Block #	Instructions/Description of Information to Include

1. **Medicaid** - Must be complete for all claims. Indicate in the second block the type of service being billed.

1a. **Insured's I.D. Number** – enter the client's 9 digit Medicaid Identification Number.

2. **Patient's Name** – (last name, first name, MI)

9d. **If applicable: Insurance Plan or Program Name** – Enter the name of the insurance or program (i.e. Blue Cross/Blue Shield, etc.) **only** if there is private insurance coverage in addition to Medicaid.

10a. **If applicable: Employment** – Check "Yes" or "No" to indicate if services described in item 24 are employment related.

10b. **If applicable: Auto Accident** – Check "Yes" or "No" to indicate if services described in item 24 are related to an auto accident.

10c. **If applicable: Other accident** – Check "Yes" or "No" to indicate if services described in item 24 are related to an accident of another type.

10d. **Reserved for Local Use** – Enter the total dollar amount paid by a private insurance carrier, if it was denied, enter the words "Carrier Denied" in this box. A copy of the insurance payment detail or insurance denial must be attached to paper claims or retained in the patients file for electronically filed claims. **DO NOT ENTER MEDICARE INFORMATION HERE.**

11c. **If applicable: Insurance plan Name or Program Name** – See item 9d.

11d. **If applicable: Another Health Plan?** – Enter an "X" in the box to indicate if additional insurance benefits are available to the patient. Using items 9 – 9d as a guide, identify the insurance plan, provide needed information on separate sheet of paper and attach to the claim form.

14. **If applicable: Date of Current (Illness or Pregnancy)** – Enter the date (MM/DD/YY) of the illness (1st symptom) or injury (accident) or pregnancy – OB claims must show the date the patient was first seen for the pregnancy. If item 10 part A, part B or part C was checked yes, indicating that it was an accident, enter the date of the accident or injury.

17. **Name of Referring Physician or Other Source** – Enter the name of the referring physician or other source (e.g. public health agency). **This must be complete on DME/Supplier Claims.**

17a. **ID Number of Referring Physician** – If patient is enrolled in SoonerCare and referred by their PCP/CM, the 10 digit referral number from the PCP/CM's referral form must be entered here or the claim will deny. **DO NOT ATTACH THE REFERRAL FORM TO THE CLAIM.**

18. **If applicable: Hospitalization Dates Related to Current Services.**

21. **Diagnosis or Nature of the Illness or Injury** – Enter the ICD-9-CM diagnosis code in order of importance: (1) Primary; (2) Secondary; (3) Tertiary; (4) Quaternary. These indicators will correspond to the appropriate procedures and will be listed in box 24e.

23. **Prior Authorization:** Enter the 10 digit number, if applicable.

24a. **Date(s) of Service** – "From and To" – Enter the range of consecutive days on which the same service was performed.

24b. **Place of Service** – Enter the appropriate code to indicate where each service is furnished.(See below)

11 – Office
12 – Home
21 – Inpatient Hospital
22 – Outpatient Hospital
23 – Emergency Room
24 – Ambulatory Surgical Center
25 – Birthing Center
26 – Military Treatment
31 – Skilled Nursing Facility
32 – Nursing Facility
33 – Custodial Care Facility
34 – Hospice
41 – Ambulance – Land
42 – Ambulance Air or Water
51 – Inpatient Psychiatric Facility
52 – Psychiatric Facility Partial Hospital
53 – Community Mental Health
54 – Intermediate Care Facility/MR
55 – Residential Substance Abuse Treatment Facility
56 – Psychiatric residential Treatment Center
61 – Comprehensive IP Rehabilitation
62 – Comprehensive OP Rehabilitation Facility
65 – End Stage Renal Disease Treatment Facility
71 – State or Local Public Health
72 – Rural Health Clinic
81 – Independent Laboratory
99 – Other Unlisted Facility

24d. **Procedures, Services or Supplies** – Enter the procedure code (CPT or HCPCS Code) for the service rendered and modifier, if applicable.

24c. **Diagnosis Code** – Enter the numeric codes (1, 2, 3, or 4) in order of importance which corresponds to the ICD-9-CM diagnosis code listed in item 21: (1) Primary; (2) Secondary; (3) Tertiary; (4) Quaternary for each procedure.

24f. **Charges** – Enter the charge for each line item on the claim form. Do not list one charge for several line items.

24g. **Days or Units** – Enter the appropriate number of days or units.

25. **Federal Tax ID Number** – Enter the Tax ID Number that belongs to the pay-to.

27. **Accept Assignment** – Indicate “Yes” in the box.

28. **Total Charge** – Enter the total of all charges listed in item 24f. Each claim must have a total.

29. **Amount Paid** – Enter the amount paid by the patient, if any.

30. **Balance Due** – Calculate and enter the amount remaining after insurance and other payments are subtracted from the total charges.

WHERE TO SEND YOUR ORIGINAL, REFILED, RESUBMITTED, FOLLOW-UP, CORRECTED AND TIMELY FILING CLAIMS

1. If you are billing on form **HCFA 1500**, mail to:
   EDS Corporation
   PO Box 54740
   Oklahoma City, OK 73154

2. If you are a Dentist, Transportation provider or a Physician billing for Medicare Crossover (**HCFA 1500**), mail to:
   EDS Corporation
   PO Box 18110
   Oklahoma City, OK 73154

3. If you are billing on form **UB-92** or provide Lab, DME, Home Health Agency or Chiropractic services, mail to:
   EDS Corporation
   PO Box 18430
   Oklahoma City, OK 73154

4. If you are **Pharmacy**, mail to:
   EDS Corporation
   PO Box 18650
   Oklahoma City, OK 73154

5. If you are a **Nursing Facility**, mail to:
   EDS Corporation
   PO Box 54200
   Oklahoma City, OK 73154

6. If you are an **Electronic Media Claim** (EMC) biller, mail tapes, diskettes, etc. to:
   EDS Corporation
   PO Box 54400
   Oklahoma City, OK 73154

7. If you are a **Waiver Provider**, mail Waiver Claims to:
   EDS Corporation
   PO Box 54016
   Oklahoma City, OK 73154

8. If you have questions regarding **Department of Rehabilitation** (claims with R prefixes), send written inquires to:
   Department of Rehabilitation Services
   PO Box 36659
   Oklahoma City, OK 73135

SOONERCARE Monthly PMP Enrollment Roster

The **Monthly PMP Enrollment Roster** is a report delivered to each PCP/CM's physical location before the end of the month. The enrollment roster lists ***SoonerCare*** members who chose or were auto-assigned to that PCP/CM for the upcoming month.

Rosters will include sections that contain new, returning, and terminated members.

The **Monthly PMP Enrollment Roster** may be incomplete. OHCA can assign members through the last day of the month. Because of this possibility, eligibility should be verified via EVS, a swipe card reader, PC software, via the internet, or your ***SOONERCARE*** **CAPITATION PAYMENT LISTING.**

See the following example of the ***SOONERCARE*** **Monthly PMP Enrollment Roster.**

OKLAHOMA MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
MONTHLY PMP ENROLLMENT ROSTER
EFFECTIVE DATE: 04 / 01 / 2003

PMP Identification Number : 100000000B
PMP Name : SMITH ROGER
Address 1 : BUGTUSSLE PCPCM
Address 2 : 444 W SAWBONES
City, State ZIP : BUGTUSSLE, OK 70000-0000

NEW ENROLLEES

RECIP ID / SSN LAST NAME, FIRST NAME MI	STREET ADDRESS 1 STREET ADDRESS 2 CITY, STATE ZIP	SEX DATE OF BIRTH/ DEATH	ASSIGNMENT EFFDATE/ ENDDATE	RACE LANG IND	COUNTY/ OFFICE IND	PHONE NO	HNDCAP IND	START STOP RSN	DATE EPSDT EXAM	CAP CAT
000000000 /000000000 ADAMS, ADAM Q	746 S MISSISSIPPI EVE ADAMS BUGTUSSLE, OK 70000-0000	M 01/21/1964	03 / 01 / 2003 12 / 12 / 2299	H ENG	01 C	(000) 000-0000	N	20		CM
234876198 / 987654321 ARQUETTE, JUSTIN D	4520 N SANDBOX CATTOWN, OK 70111-0077	M 04 / 23 / 1932	03 / 01 / 1992 12 / 12 / 2299	H ENG	01 C	(111) 111-1111	N	20		TY
821638492 / 829384756 BOGGS, HALE G	234 W ALABAMA CATTLECALL, OK 70112-0101	M 05 / 23 / 1944	04 / 01 / 2000	H ENG	01 C	(405)112 -2233	N	28		TG
928356749 / 647382395 HATFIELD, DIVEL A	995 E MOUNTAINDELL FEUDIN, OK 74555-5566	M 12 / 12 / 1985	10 / 10 / 1990	H ENG	01 C	(580) 123-4567	N	20		TY
033177796 / 512985681 BROWN, DON C	101 SE CHICKENSACK BATTLEAXE, OK 74748-7789	F 09 / 17 / 1992	04 / 01 / 2003	H ENG	74 C	( ) -	N	28	08 / 30 / 02	TY
033221975 / 509085253 BROWN, RIZEY S	101 SE CHICKENSACK BATTLEAXE, OK 74748-7789	F 05 / 16 / 1991	04 / 01 / 2003	H ENG	74 C	( ) -	N	28	08 / 30 / 02	TY
033176696 / 510161568 BROWN, DAN E	101 SE CHICKENSACK BATTLEAXE, OK 74748-7789	M 01 / 20 / 1989	04 / 01 / 2003	H ENG	74 C	( ) -	N	28	08 / 30 / 02	TY
033176777 / 519766333 BROWN, SHARING D	101 SE CHICKENSACK BATTLEAXE, OK 74748-7789	F 01 / 11 / 1964	04 / 01 / 2003	H ENG	74 C	( ) -	N	28		TF
578490843 / 987578153 CRATCH, LATISHA	622 W TOOL NOWATER, OK 74448-3345	F 01 / 25 / 1984	04 / 01 / 2003	H ENG	53 C	(000) 273-0641	N	20		TG
837465872 / 927583687 DUMAS, RONNIE E	352 N PAW NOWATER, OK 74448-3345	M 04 / 22 / 1992	04 / 01 / 2003	H ENG	53 C	(000) 273-9190	N	20		TY

SOONERCARE CAPITATION PAYMENT LISTING
For Period: (Month of)

The **capitation payment listing** is a monthly report delivered to each PCP/CM, according to the PCP/CM's instructions in the contract, and is delivered by regular mail. At the same time, an electronic deposit is made or a warrant is enclosed representing the capitation payment for the specified period. The listing and **payment are sent by the 10th business** day of the month.

The **capitation payment listing** is a current listing of all ***SoonerCare*** members enrolled with, or assigned to, a PCP/CM for the specified month. Adjustments to previous capitation payment listings may also be included, when appropriate. **Please review this information in a timely manner**, so that you know your records are correct and your dollars are correct. Continue to verify eligibility and assignment through the EVS.

Report : 58700349 – M
Process : MGDIJ500
Location : MGD0055M

OKLAHOMA MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
CAPITATION PAYMENT LISTING
DATE RANGE: 02 / 01 / 2003 - 02 / 28 / 2003

Run Date: 02/30/2
Run Time : 00:03

PMP Identification Number : 100000000B
PMP Name : SMITH ROGER
Address 1 : BUGTUSSLE PCPCM
Address 2 : 444 W SAWBONES
City, State ZIP : BUGTUSSLE, OK 70000-0000

Payment Issue Date: 02 / 05 / 2003
Payment No: 00807012
Total Amount: 3952.57

RECIPIENT ID	RECIP NAME	CASE NUM	EFF DATE	END DATE	AMOUNT PAID	ADJUSTMENT AMOUNT
000152573	CLINE, PATSY L	C340211	02 / 01 / 2003	02 / 28 / 2003	12.59	0.00
001709088	NICKLE, DON M	C599522	02 / 01 / 2003	02 / 28 / 2003	14.02	0.00
002162709	SUMMERS, SUZANNE	C008933	02 / 01 / 2003	02 / 28 / 2003	22.76	0.00
008023782	CHASTAIN, BRANDI L	C007368	02 / 01 / 2003	02 / 28 / 2003	24.49	0.00
005829490	SMITH, HARRY	C839274	02 / 01 / 2003	02 / 28 / 2003	14.66	0.00
002847563	PRINCE, FREDDY	C173464	02 / 01 / 2003	02 / 28 / 2003	12.59	0.00
006373737	FLANAGAN, MAGGIE C	D003745	02 / 01 / 2003	02 / 28 / 2003	24.49	0.00
009874566	COOPER, GARY W	C062535	02 / 01 / 2003	02 / 28 / 2003	8.93	0.00
008926344	COOPER, MEMORY	C062535	02 / 01 / 2003	02 / 28 / 2003	8.93	0.00
006542389	COOPER, TIMOTHY Q	C073737	02 / 01 / 2003	02 / 28 / 2003	11.19	0.00
007529038	DOMINIC, DUNNE L	C022523	02 / 01 / 2003	02 / 28 / 2003	14.66	0.00
007272663	WILBOURN, FREDA W	C083648	02 / 01 / 2003	02 / 28 / 2003	14.66	0.00
002452345	STRONG, IMA M	C141737	02 / 01 / 2003	02 / 28 / 2003	12,59	0.00
0082E4628	STRONG, URA S	C141737	02 / 01 / 2003	02 / 28 / 2003	11.19	0.00
000177573	CLIMB, PATSY M	C940211	02 / 01 / 2003	02 / 28 / 2003	12.59	0.00
001733088	NICKLES, DON T	C499522	02 / 01 / 2003	02 / 28 / 2003	14.02	0.00
005672709	SLUMBERS, SUZANNE	C778933	02 / 01 / 2003	02 / 28 / 2003	22.76	0.00
008983782	CHRISTIAN, RANDI L	C347368	02 / 01 / 2003	02 / 28 / 2003	24.49	0.00
006452573	SMITH, BARRY	C789274	02 / 01 / 2003	02 / 28 / 2003	14.66	0.00
008799088	PRICE, FREDDY	C563464	02 / 01 / 2003	02 / 28 / 2003	12.59	0.00
002565709	FINAGAN, MACCIO C	D453745	02 / 01 / 2003	02 / 28 / 2003	24.49	0.00
008343782	COOPER, GARY O	C342535	02 / 01 / 2003	02 / 28 / 2003	8.93	0.00
002874745	COOPER, MICHAEL	C342535	02 / 01 / 2003	02 / 28 / 2003	8.93	0.00
000192573	COPPER, TIM I	C342537	02 / 01 / 2003	02 / 28 / 2003	11.19	0.00
001755088	DOMINO, DUECE E	C902523	02 / 01 / 2003	02 / 28 / 2003	14.66	0.00
002158809	WILBURN, FREDA B.G.	C893648	02 / 01 / 2003	02 / 28 / 2003	14.66	0.00
008354378	STRONG, HESA	C781737	02 / 01 / 2003	02 / 28 / 2003	12,59	0.00
008726562	STRONG, THERA	C781737	02 / 01 / 2003	02 / 28 / 2003	11.19	0.00
008751923	ANATEU, JUAN	D454756	02 / 01 / 2003	02 / 28 / 2003	24.49	0.00

CLAIMS PAID

Remittance Statements are received in response to your claim filing. Payments documented on the remittance statements are deposited electronically or paid by warrant.

If you are having difficulty filing claims, call Customer Services or your EDS Field Consultant.

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

FRANK KEATING
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

OHCA 2001-33

December 21, 2001

Dear Medical Provider:

This letter is a reminder that the Oklahoma Health Care Authority Board approved revisions to the Medicaid fee-for-service rules regarding timely filing of claim resubmissions and the Governor signed these rules.

After the submission of a claim from a provider, which has been adjudicated by the Oklahoma Health Care Authority, a provider may resubmit the claim under the following rules:

- The provider must have submitted the claim initially under the timely filing requirements found at OAC 317:30-3-11.

- The provider's resubmission of the claim must be received by the Oklahoma Health Care Authority no later than 24 months from the date of service. This includes claims requiring adjustments, reconsideration and requests for additional documentation.

- The only exceptions to the 24-month resubmission claim deadline are the following:

    a) Administrative agency corrective action or agency actions taken to resolve a dispute.
    b) Reversal of the eligibility determination.
    c) Investigation for fraud or abuse of the provider.
    d) Court order or hearing decision.

A letter with documentation for the exception must be attached to your claim and addressed to Customer Service, PO Box 18506, Oklahoma City, OK 73154.

If you have any questions, please visit our website at www.ohca.state.ok.us, clicking on the ***Provider*** caption to access and review the rules, accessing specifically Chapter 30, or; please contact **Customer Service at (800)522-0114 (In-state only) or (405)522-6205.**

Sincerely,

Mike Fogarty

Notes:

EVS
Eligibility Verification System

The **Eligibility Verification System (EVS)** verifies member eligibility, managed care information, provider warrant information and prior authorizations.

The EVS is available 20 hours/day – 5:00 a.m. to 1:00 a.m. by calling 1-800-767-3949 or (405) 840-0650.

To use the EVS, PCP/CMs will need a current provider I.D. number and PIN number.

EVS can be accessed through:

1. Free Telephone Dial–In EVS
2. Commercial EVS Vendor Swipe Machine
3. IBM/PC EVS Software
4. Internet

A set of instructions and vendor information is included inside the front cover of this manual.

Notes:

Provider Help
Nurse Advice Line

The Nurse Advice Line is a service available for ***SoonerCare*** members only.

Audio Tape Library

The Member Handbook lists just a few of the more than 1100 recorded topics accessible on the Nurse Advice Line. "Parenting and Family Life" is one of the many health related topics available for ***SoonerCare*** members.

The ***SoonerCare*** Nurse Advice Line:

- is accessible 24 hours a day, 7 days a week.
- offers triage services to members based on nationally recognized triage protocols
- is staffed by professional Registered Nurses.

Translation Services

A direct benefit of the Nurse Advice Line to the PCP/CM is the translation service that is available 24 hours a day, seven days a week. If you cannot communicate with the member because of language, call the Nurse Advice Line.

The Nurse Advice Line contracts with AT&T's translator service that can accommodate more than 140 languages and dialects. Physicians with a ***SoonerCare*** member in the office who does not speak English can call the Nurse Advice Line, which will connect them with an AT&T translator during the visit. The Nurse Advice Line can also connect with the service any time a non-English speaking customer Calls.

After Hours

Your after hours recording may instruct your ***SoonerCare***

members to call the Nurse Advice Line, however the Advice Line does **NOT** take the place of the provider's role in after-hours coverage but serves as a supportive program.

The Nurse Advice Line will offer assistance in determining if the caller truly has an emergency or urgent care need, and educate the caller about home care.

Notes:

ER Visit Notification

If the NAL directs the member to seek emergency room care, your office will receive fax notification the next business day as will the ***SoonerCare*** Division of the OHCA.

SoonerCare Nurse Advice Line
1-800-530-3002
or for the hearing impaired
dial Southwestern Bell Relay Oklahoma at
1-800-722-0353 (TDD/TTY)

Provider Help

In-Office Resources

It is recommended that PCP/CMs consider the following publications as in-office resources for their staff.

Current Procedural Terminology cpt.
American Medical Association, Physicians dedicated to the health of America. AMA Press.

Physician ICD 9 CM. Medicode's Publications & Software For Coders. Medicode, 5225 Wiley Post Way, Suite 500, Salt Lake City, UT 84116. (801) 536-1000. Fax (801) 536-1011.

HCFA Common procedure Coding System (HCPCS). Medicode, 5225 Wiley post Way, Suite 500, Salt Lake City, UT 84116. (801) 536-1000. Fax (801) 536-1011.

Notes:

Member Help
Education/Information

Notes

PCP/CMs are encouraged to educate ***SoonerCare*** members in the appropriate use of medical services; under utilization and over utilization; and appropriate use of the emergency room. The ***SoonerCare*** Member Handbook is a useful tool for this process.

PCP/CMs are urged to communicate their office policies with the members who are assigned to them. This could include appointment scheduling, cancellation of appointments, etc. Page 7 of the Member Handbook concerns appointments, including urgent care. This is a great tool to use with members in your office or on the phone.

Familiarizing your office and staff with the Member Handbook may help educate members on their responsibilities as ***SoonerCare*** members.

Members should be made aware of self-referral options. Self-referral services that do not require a referral from the PCP/CM are:

- Basic dental care if under age 21
- True emergency care
- Family planning services for adolescents under age 18
- Mental health and substance abuse services
- Basic vision care if under age 21
- Pharmacy
- OB services
- Child physical and sexual abuse exams

Member Help
Nurse Advice Line

Notes

The Nurse Advice Line is a service available for ***SoonerCare*** members only.

SoonerCare members are provided information about the Nurse Advice Line in the ***SoonerCare*** Member Handbook.

Audio Tape Library

The Member Handbook lists just a few of the more than 1100 recorded topics accessible on the Nurse Advice Line. “Parenting and Family Life” is one of the many health related topics available for ***SoonerCare*** members.

Translation Services

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After Hours

Our after hours recording may instruct your ***SoonerCare*** members to call the Nurse Advice Line, however the Advice Line does **NOT** take the place of the provider’s role in after-hours coverage but serves as a supportive program.

The Nurse Advice Line will offer assistance in determining if the caller truly has an emergency or urgent care need, and educate the caller about home care.

SoonerCare Nurse Advice Line
1-800-530-3002
or for the hearing impaired
dial Southwestern Bell Relay Oklahoma at
1-800-722-0353 (TDD/TTY)

Member Help

SoonerCare Helpline

Notes

The ***SoonerCare*** Helpline is a toll-free telephone number that ***SoonerCare*** members can call for general information and assistance with enrollment or changing a PCP/CM.

Translation Services

The ***SoonerCare*** Helpline has at least one staff member who speaks Spanish and can be immediately accessed for translation services. For members who speak languages other than English or Spanish the Helpline contracts with AT&T's translator service that can accommodate more than 140 languages and dialects.

SoonerCare members are instructed to call the Helpline:

- if they are unable to contact their PCP/CM for an appointment
- to change their PCP/CM
- to request a new Medical I.D. Card
- if they have enrollment or general information questions
- if they need information about basic benefits and services

The ***SoonerCare*** Helpline is available Monday through Friday 8 a.m. to 5 p.m.

Members are provided information about the ***SoonerCare*** Helpline in the Member Handbook.

Members can obtain a ***SoonerCare*** Member Packet that includes a Member Handbook and a Provider Directory from the Helpline.

SoonerCare Helpline
1-800-987-7767
or
For the hearing impaired
1-800-757-5979 (TDD/TTY)

Member Help

SoonerRide

SoonerRide is a Non-Emergency Transportation Service available in all counties to assist members with transportation to PCP/CM appointments, clinics, pharmacy or hospital for services covered by ***SoonerCare.*** For more information refer to the SoonerRide brochure in the inside flap of the front cover.

SoonerRide transportation service is available 6:00 a.m. to 8:00 p.m. weekdays and 8:00 a.m. to 1:00 p.m. Saturdays.

SoonerCare members should call at least 3 days in advance. Transportation for urgent care may not be available if calling less than 3 days in advance.

All ***SoonerCare*** members are provided information about **SoonerRide** in the ***SoonerCare*** Member Handbook.

SoonerRide
1-877-404-4500

For the hearing impaired
Southwestern Bell Relay Oklahoma at
1-800-722-0353 (TDD/TTY)

Notes

Quick Reference
Telephone Numbers

OHCA Main Number	(404) 522-7300
Adjustments	(405) 522-7450
Customer Service	
Providers	(405) 522-6205 1-800-522-0114
Recipients	(405) 522-7171 1-800-522-0310
Fax	(405) 522-7178
Customer Services Claim Status Line	
Providers	1-800-522-0114
Recipients	1-800-522-0310
Health Policy Division	(405) 522-7440
Legal-Appeals/Grievances	(405) 522-7217
Level of Care Evaluation Unit	(405) 522-7288
Long Term Care	(405) 522-7413
Managed Care Division	(405) 522-7200
SoonerCare Contractor Services	1-877-823-4529
SoonerCare Helpline	1-800-987-7767

SoonerCare Nurse Advice Line	1-800-530-3002
Medical and Health Policy Services	(405) 522-7382
Medical Management	(405) 522-7382
Med. Authorization	(405) 522-7555
Med. Case Management	1-877-252-6002
OU College of Pharmacy Helpline	(405) 271-6349 1-800-831-8921
Outreach and Marketing	(405) 522-7484
Provider Enrollment Unit – Medicaid FFS Contracts	(405) 522-6205 1-800-522-0114
REVS - Recipient Eligibility Verification System	(405) 840-0650 1-800-767-3949
SoonerRide	1-877-404-4500
Supply Line	(405) 522-7375
Suspected Child Abuse Hotline	1-800-522-3511
Third Party Liability	(405) 522-7451 1-800-268-5261
Vaccines for Children	(405) 271-4073
Care Management	1-877-823-4529 press option 9

Quick Reference
CALL TREE

Client Lines Toll Free (800) 522-0310 Oklahoma City (405) 522-7171	**Provider Lines** Toll Free (800) 522-0114 Oklahoma City (405) 522-6205
1 – Eligibility questions / DHS	1 – Fee-for-service, ***SoonerCare*** claim status
2 – Claim Status / EDS Call Center	2 – Eligibility / EVS
3 – ***SoonerCare*** Member Services	3 – Care Management
4 – Enrollment Agent / First Health	4 – Pharmacy Help Desk
5 – Nurse Advice Line / First Health	5 – Provider Contracts
6 – Spanish Assistance / EDS Call Center	6 – Adjustments
	7 – TPL
	8 – PIN resets/ EDI/ Medicaid on the Web Assistance 1. Security Help Desk 2. EDI Help Desk 3. Medicaid on the Web Help Desk
	9 - Prior Authorizations 1. Medical 2. Dental
9 – Repeat Options	* – *Repeat Options*

Glossary/Definitions

Notes

ABD (Aged, Blind and/or Disabled) – a category of Medicaid eligibility based upon age, medical diagnosis and/or disability.

ABD Bridge Payment - a supplemental payment made to a PCP/CM for the ABD patients assigned to the PCP/CM to offset the financial risk if the PCP/CM's capitation payments are less than the fee for service equivalent. (See Contract Section 4.14)

Case Management – includes but is not limited to:

- providing direct health care to patients
- providing medically necessary specialty referrals, including standing referrals
- coordinating admissions to hospital
- making appropriate referrals to the Women Infants and Children (WIC) program
- coordinating and monitoring all family centered medical care on behalf of a member
- coordinating with community mental health professionals and Indian health Services, tribal and urban Indian providers
- educating patients to appropriately use medical resources such as emergency rooms and medical advice lines.

Encounter Claims – claims submitted to document the provision of pre-paid primary care services.

Emergency Medical Condition – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected, by a prudent layperson, to result in:

⇒ placing the health of the individual (or, with a pregnant woman, the health of her unborn child) in serious jeopardy, or
⇒ serious impairment to any bodily functions, or
⇒ serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions:

⇒ inadequate time to effect a safe transfer to another hospital before delivery, or transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of Emergencies:

- Heart attack symptoms
- Head injuries
- Bleeding that can't be stopped

- Serious trouble breathing
- Suspected poisoning
- Broken bones
- Drug overdoses

EPSDT – Early and Periodic Screening, Diagnosis and Treatment. A program mandated in federal regulations that covers screening and diagnostic services for enrollees under the age of 21 to determine physical and mental defects and ascertain health care treatment and other measures to correct or ameliorate any defects and chronic conditions which are found.

Family Planning Services - An office visit for a comprehensive family planning evaluation, including obtaining a Pap smear. Family Planning services do not include a pathologist's lab fee.

Member - Medicaid eligible or a Title XIX eligible person who is enrolled with a PCP/CM. This term is interchangeable with the terms enrollee, patient, recipient and beneficiary.

Obstetrical Services – prenatal care, delivery and sixty (60) days of postpartum care.

Panel – group of recipients/patients who have selected or been assigned to a PCP/CM for health care. Interchangeable with Roster.

Patient - same as Member.

PCP/CM – primary care provider/case manager.

Pharmacy – (Provider Manual 317:30-5-70. Through 317:305-86.2.) Prescription drugs for children in Choice (under age 21) are not limited in number. Prescription drugs for adults in Choice (age 21 and over) are limited to three per month. (This is true unless the patient is in a nursing facility or Intermediate Care Facility for the Mentally retarded who have all medically necessary drugs covered with some exceptions. After 30 days in a nursing facility a Choice member is excluded from the Choice program.)
Some drugs are exempt from the three drug limit including but not limited to anti-neoplastics, birth control contraceptives, hemophilia drugs, compensable smoking cessation products and drugs used in the treatment of tuberculosis.
Prescription quantities are to be limited to 34 day supply or 100 dosage units, whichever is greater, except in instances where the manufacturer recommends a lesser amount. (Refer to 317:30-5-77.1.) In an emergency situation the Health Care Authority will authorize a 72 hour emergency supply of medications which does not count against the Medicaid limit.

Provider – an individual, partnership, limited partnership, limited liability company, corporation, or professional corporation composed of doctors of medicine and/or doctors of osteopathy and/or advanced practice nurse practitioner and/or physicians assistants who provide health care of the nature provided by independent practitioners and is permitted by State and federal law and regulations to receive Medicaid provider payments.

Primary Care Services – consists of all services listed in Attachment A to the contract. Primary Care Services includes family planning services for recipients over eighteen (18) years of age and those recipients less than eighteen (18) years of age who present to the PCP/CM for such services.

Prior Authorization – Approval of services in the fee-for-service Medicaid program is required before payment can be made. Examples of services for which prior authorizations must be approved include, but are not limited to, wheelchairs, hearing aids, inpatient psychiatric care and some medications.

Recipient – same as patient.

Urgent Medical Condition – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse), such that a reasonably prudent lay person could expect that the absence of medical attention within twenty-four (24) hours could result in:

- placing the health of the individual (or with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy; or
- serious impairment to bodily function; or
- a serious dysfunction of any bodily organ or part.

Stop-Loss for TANF – a provision for insuring that the PCP/CM will not incur unreimbursed costs for providing primary care services to TANF members assigned to the PCP/CM over and above what the fee-for-service equivalent threshold is reached. (See Contract Section 5.13)

Vision Services – examinations and refractive services provided by optometrists or ophthalmologists, within the legal scope of their practice.

FAQ (Frequently Asked Questions)

Notes

Q. What services are covered by my capitation?

The list of capitated services is located in Attachment A of the ***SoonerCare*** contract. It includes office visits, preventive visits, immunizations, injections and limited lab and x-ray services.

Q. When do we get paid each month?

Capitation payments are due to the provider by the tenth business day of the month.

Q. How can we check eligibility for members?

Eligibility should be checked through the REVS system. An informational brochure is included in the training manual. This is the most current eligibility information available.

Q. Why do we need to file claims for capitated services?

It is extremely important that providers file claims for all services rendered regardless whether they are capitated services or not. Future capitation rates are determined using this information, as well as EPSDT bonus payments, TANF stop-loss, and ABD bridge payments.

Q. How can members enroll with me?

Members may enroll with a provider several ways. They may enroll by telephoning the SoonerCare Helpline, via Provider Change Request Action Forms. The most efficient way to enroll is through the SoonerCare Helpline.

Q. How many times can a member change their PCP/CM?

Members may change their PCP/CM up to four times per year.

Q. Can members be removed from my roster?

Members may be removed from a PCP/CM's roster **for cause** only and are subject to approval by the OHCA Medical Director. Providers may not discharge a member until authorization from OHCA has been received. See the contract for the definition of "for cause" and dismissal procedures.

Q. Why do members come and go on my list each month?

See Member Enrollment Section.

Q. How soon do appointments need to be scheduled?

Urgent needs should be scheduled within 24 hours. Routine and non-urgent appointments should be made available within 3 weeks or longer if the condition requires less frequent attention.

Q. How often do children need EPSDT exams?

The periodicity schedule is included in the ***SoonerCare*** contract. The minimum number of visits is based on the age of the member.

Q. What vaccines are we required to give adults?

Four vaccines are listed on Attachment A of the SoonerCare Choice Contract, Tetanus, Pneumococcal, Hepatitis and Adult Flu. These vaccines should be given when it is medically appropriate for the adult based on CDC risk criteria. These vaccines are not available thorough the Vaccines For Children Program and must be purchased by the PCP/CM.

Q. If we cannot provide a capitated lab or x-ray service what do we do?

If a provider cannot provide a capitated lab or x-ray service these must be purchased by the PCP/CM from an outside provider. No additional reimbursement will be made for these services. Outside providers may only charge the PCP/CM up to the Medicaid Fee-For-Service equivalent for these purchased services.

Q. When is it appropriate to write a referral?

Referrals should be written for medically necessary services that fall outside the PCP/CM's scope of practice or field of expertise. Capitated services that can be provided by the PCP/CM should not be referred to other providers.

Q. How long are referrals good for?

Referrals may be written for an initial visit only or for up to 12 months. Referrals written for up to 12 months for the same medical reason are valid through the period of time they were

written even if a member changes their PCP/CM.

Q. I have never seen the patient. Do I have to write referrals for them?

Referrals are written at the discretion of the PCP/CM. The PCP/CM does not have to provide referrals in these situations if he/she does not feel it is appropriate. You may want to request documentation for the treating provider in order to make your decision.

Q. Does a referral have to be written for each specialist a member sees?

No. Referrals may be forwarded from one provider to another for services related to the original referral. The PCP/CM must be contacted by the "referred to" provider for approval.

Q. If I am out of the office can a referral be written to another provider?

No. Coverage must be arranged by the PCP/CM for times when the provider is unavailable. This is an agreement between the providers and no additional reimbursement is due for capitated services. If the covering provider renders a service that is non-capitated, a referral would be necessary in order for the provider to be reimbursed.

Q. How can I find a specialist to see my patients?

SoonerCare provides Exceptional Needs Coordinators to assist you in locating specialty providers for your ***SoonerCare*** patients. Please contact your Provider Representative if you need this assistance.

Q. Where can members get help with transportation?

SoonerRide provides non-emergency transportation services to ***SoonerCare*** members and some fee-for-service recipients. For more information please refer to the informational brochure in your handbook.

Q. I have non-English speaking members, are translation services available?

The ***SoonerCare*** Nurse Advice Line offers translation

services for PCP/CMs in their office. They may be reached at toll free 800-530-3002.

Q. I have a question on the processing of a claim. Who do I call?

The Oklahoma Health Care Authority provides customer service representatives to assist you in questions concerning claims information. They may be reached toll free at 800-522-0114.

Q. How do I order referral forms?

Referral forms may now be printed from the OHCA website. If you do not have internet access referral forms and other materials may be ordered through the EDS Supply Line. This is a message phone only. Please leave a message with your name, provider's name and complete mailing address for prompt processing.

Q. What materials are available as information handouts to my patients?

SoonerCare Choice provides several postcards that are available to PCP/CMs. These include EPSDT cards, Nurse Advice Line cards and others. Please contact your ***SoonerCare*** Provider Representative if you wish to obtain a supply of cards.

Q. How do I qualify for an EPSDT bonus?

PCP/CMs must have been contracted for a full contract year and meet the bonus threshold in order to qualify. OHCA will conduct audits of encounter date received by February 1st of the following year.