Division of Medical Assistance Programs

Policy and Planning Section

Medical-Surgical Services Administrative Rulebook

Chapter 410, Division 130

Effective January 1, 2015

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410-130-0000 – Foreword

(1) The Division of Medical Assistance Programs (Division) Medical-Surgical Services rules are designed to assist medical-surgical providers to deliver medical services and prepare health claims for clients with Medical Assistance Program coverage. Providers must follow the Division rules in effect on the date of service.

(2) The Division enrolls only the following types of providers as performing providers under the Medical-Surgical program:

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Podiatrists;

(c) Acupuncturists;

(d) Licensed Physician assistants;

(e) Nurse practitioners;

(f) Laboratories;

(g) Family planning clinics;

(h) Social workers (for specified services only);

(i) Licensed Direct entry midwives;

(j) Portable x-ray providers;

(k) Ambulatory surgical centers;

(l) Chiropractors;

(m) Licensed Dieticians (for specified service only);

(n) Registered Nurse First Assistants;

(o) Certified Nurse Anesthetists;

(p) Clinical Pharmacists;

(q) Birthing Centers.

(3) For clients enrolled in a managed care plan, contact the client's plan for coverage and billing information.

(4) The Medical-Surgical Services rules contain information on policy, special programs, prior authorization, and criteria for some procedures. All DMAP rules are intended to be used in conjunction with the General Rules for Oregon Medical Assistance Programs (OAR 410 division 120) and the Oregon Health Plan (OHP) Administrative Rules (OAR 410 division 141).

(5) The Health Services Commission's Prioritized List of Health Services is found on their website at: http://www.oregon.gov/OHPPR/HSC/

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-130-0005 – Federally Qualified Primary Care Provider

(1) Section 1202 of the Affordable Care Act (ACA) amended sections 1902(a)(13), 1902Uj), 1905(dd) and 1932(f) of the Social Security Act to require increased Medicaid payment for primary care services to qualified providers for calendar years 2013 and 2014 as specified in these rules.

(2) Federally Qualified Primary Care Services are designated as:

(a) Evaluation and Management (E&M) Current Procedural Terminology (CPT) codes 99201 through 99499; and

(b) Vaccine administration CPT codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes; and

(c) Administration of vaccines under Vaccines for Children Program (refer to OAR 410-130-0255).

(3) To qualify for the increased payment, the individual physician must attest that:

(a) The physician has a primary practice in family medicine, general internal medicine, or pediatric medicine; and

(b) One or both of the following are true:

(A) The physician is Board-certified in a specialty or subspecialty of family medicine, general internal medicine, or pediatric medicine by one of the following boards:

(i) The American Board of Medical Specialties (ABMS);

(ii) The American Osteopathic Association (AOA);

(iii) The American Board of Physician Specialties (ASPS);

(B) The physician can demonstrate that at least 60 percent of the procedure codes billed and paid in Medicaid claims were qualifying primary care codes described in section 2 of this rule.

(i) Over the previous calendar year, if billings exist for this time period; or

(ii) Over the previous month, if billings do not exist for the previous calendar year.

(4) To qualify for the increased payment, a Physician Assistant (PA) or Nurse Practitioner (NP) must attest that they work under the direct supervision of a Physician who:

(a) Qualifies for increased primary care payments as described in these rules; and

(b) Assumes professional responsibility for the services rendered by the PA or NP.

(5) Providers seeking the reimbursement increase from the Division of Medical Assistance Programs (Division) must self-attest with the Division. Providers, not enrolled with the Division, seeking the increase from OHP health plans (MCO or CCO), must self-attest with the applicable MCO or CCO.

(6) Reimbursement: Effective for dates of service on or after January 1, 2013, the Division shall reimburse primary care providers as follows:

(a) Federally qualified primary care providers as described in this rule at the rate specified in OAR 410-120-1340(6)(C)(ii); or

(b) Other primary care providers, including potentially qualified providers who do not self-attest to the Division as described in part (3) of this rule, at the rate specified in OAR 410-120-1340(6)(C)(iii).

(7) Annual review of qualifying providers: The Division will review a statistically valid sample of providers to determine whether they satisfy the criteria described in (3) and (4) of these rules. Providers reviewed who do not satisfy the criteria will be required to reimburse the Division for the difference between the rate they should have received according to OAR 410-120-1340(6)(C)(iii) and enhanced rate in OAR 410-120-1340(6)(C)(ii). The sample will include the following providers:

(a) Physicians who have self-attested to qualifying for the increased rate; and

(b) Providers who have self-attested that they are under the direct supervision of a qualified physician.

(8) Supplemental information on primary care reimbursement under the Affordable Care Act is available at
http://www.oreqon.gov/oha/healthplan/pages/tools_prov/pcp-rates.aspx.

Stat Auth.: ORS 413.042

Stats Implemented: 414.025 and 414.065

410-130-0015 – Doula Services

(1) The primary purpose of providing concurrent doula services with the services of a licensed obstetrical practitioner is to optimize birth outcomes, including reduced Caesarian sections, epidural use, reduced assisted vaginal deliveries, and reduce the number of neonatal care unit admissions. These face-to-face services are provided only during the labor and delivery phase of the client's pregnancy. The following are expected to benefit most from doula services:

(a) A woman with a racially or ethnically diverse background including, Black/African American, Asian, Pacific Islander, Native American, Latino or multiracial;

(b) A homeless woman;

(c) A woman who speaks limited to no English;

(d) A woman who has limited to no family or partner support; or

(e) A woman who is under the age of 21;

(2) Doula services may be provided only at the request of the licensed obstetrical practitioner. The doula and licensed obstetrical practitioner must work concurrently. The licensed obstetrical practitioner must be a physician or advance practice nurse.

(3) Doulas must be certified and registered with the Authority pursuant to OAR 410-180-0325 through 0327. Certification must be effective at the time doula services are provided. Doulas must provide proof of certification to the practitioner.

(4) Doula services are covered for any woman whose benefit package covers labor and delivery.

(5) The provision of doula services during labor and delivery must be documented in the client's medical record by the licensed obstetrical practitioner.

(6) Payment for doula's services

(a) The licensed obstetrical practitioner may be eligible for an additional payment, as remuneration for the attending doula providing the doula services;

(b) Doulas may not receive direct payment from the Division;

(c) To be considered for the additional payment, the professional claim for the delivery services must include the unique Medicaid modifier of U9 appended to the appropriate obstetrical code billed at the time of delivery;

(d) This modifier may only be billed once per pregnancy. Multiples (i.e., twins, triplets) are not eligible for additional payment for the doula's services;

(e) Only one additional payment shall be made for doula services regardless of the number of doulas providing the services;

(f) Only providers with a provider type designation of 34 or 42 may bill the U9 modifier.

(7) Doula services at the time of delivery are the only services eligible for payment under this rule. Services provided during the prenatal and postnatal period are governed by OAR 410-130-0595 (Maternity Case Management).

Stat. Authority: ORS 413.042 and 414.065

Stat. Implemented: ORS 414.065

410-130-0160 – Codes (T)

(1) ICD-9-CM Diagnosis Codes:

(a) Always use the principal diagnosis code in the first position to the highest degree of specificity. List additional diagnosis codes if the claim includes charges for services that relate to the additional diagnoses. However, it is not necessary to include more than one diagnosis code per procedure code;

(b) Diagnosis codes are required on all billings including those from independent laboratories and portable radiology including nuclear medicine and diagnostic ultrasound providers;

(c) Always supply the ICD-9-CM diagnosis code to ancillary service providers when prescribing services, equipment, and supplies.

(2) CPT and HCPCS Codes:

(a) Use only codes from the current year for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes;

(b) Effective January 1, 2005, HIPAA regulations prohibit the use of a grace period for codes deleted from CPT or HCPCS. In the past the grace period was from January 1 through March 31;

(c) The division may consider reimbursement for CPT category III codes included under the following headings: Adaptive Behavior Assessments, Adaptive Behavior Treatment, and Exposure Adaptive Behavior Treatment With Protocol Modification. All CPT category II (codes with fifth character of “F”) and all other category III codes (codes with fifth character “T”) are not Division of Medical Assistance Programs’ (Division) covered services;

(d) Use the most applicable CPT or HCPCS code. Do not fragment coding when services can be included in a single code (see the “Bundled Services” section of this rule). Do not use both CPT and HCPCS codes for the same procedure. This is considered duplicate billing.

(3) The Medical-Surgical Service rules list the HCPCS/CPT codes that require authorization or have limitations. The Health Evidence Review Commission’s Prioritized List of Health Services (rule 410-141-0520) determines covered services.

(4) For determining the appropriate level of service code for Evaluation and Management services, read the definitions in the CPT and HCPCS codebook. Use the definitions to verify level of service, especially for office visits. Unless otherwise specified in the Medical-Surgical provider rule, use the guidelines from CPT and HCPCS.

(5) Bundled Services: Reimbursements for some services are “bundled” into the payment for another service. The Division does not make separate payment for bundled services and clients may not be billed for bundled services. The Division’s Not Covered/Bundled Services rule, OAR 410-130-0220, provides more information regarding bundled services.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065

410-130-0180 – Drugs

(1) The Division of Medical Assistance Programs' (Division) Medical-Surgical Services Program reimburses practitioners for drugs only when administered by the practitioner in the office, clinic or home settings. The Division does not reimburse practitioners for drugs that are self-administered by the client, except for contraceptives such as birth control pills, spermicides and patches:

(a) Use an appropriate Current Procedural Terminology (CPT) therapeutic injection code for administration of injectables;

(b) Use an appropriate Healthcare Common Procedure Coding System (HCPCS) code for the specific drug. Do not bill for drugs under code 99070; The Division requires both the NDC number and HCPCS codes on all claim forms.

(c) When there is no specific HCPCS code for a drug or biological, use an appropriate unlisted code from the list below and bill at acquisition cost (purchase price plus postage):

(A) J3490;

(B) J3590;

(C) J7599;

(D) J7699;

(E) J7799;

(F) J8499;

(G) J8999;

(H) J9999;

(I) Include the name of the drug, National Drug Code (NDC) number and dosage.

(d) Do not bill for local anesthetics; reimbursement is included in the payment for the tray and/or procedure.

(2) Do not bill for local anesthetics; reimbursement is included in the payment for the tray and/or procedure.

(3) For codes requiring prior authorization and codes that are Not Covered/Bundled, refer to OAR 410-130-0200 Table 130-0200-1 and OAR 410-130-0220 Table 130-0220-1.

(4) Not covered services and supplies include:

(a) Laetrile;

(b) Home pregnancy kits and products designed to promote fertility;

(c) Dimethyl sulfoxide (DMSO), except for instillation into the urinary bladder for symptomatic relief of interstitial cystitis;

(d) Infertility drugs;

(e) Sodium hyaluronate and Synvisc.

(5) Follow criteria outlined in the following:

(a) Billing Requirements -- OAR 410-121-0150;

(b) Brand Name Pharmaceuticals -- OAR 410-121-0155;

(c) Prior Authorization Procedures -- OAR 410-121-0060;

(d) Drugs and Products Requiring Prior Authorization -- OAR 410-121-0040;

(e) Drug Use Review -- OAR 410-121-0100;

(f) Participation in Medicaid's Drug Rebate Program -- OAR 410-121-0157.

(A) The Division cannot reimburse providers for a drug unless the drug manufacturer has signed an agreement with the Centers for Medicare and Medicaid Services (CMS) to participate in the Medicaid Drug Rebate Program.

(B) To verify that a drug manufacturer participates in the Medicaid Drug Rebate Program, visit the CMS website below to verify that the first five digits of the NDC number (labeler code) are listed as a participating drug company:

http://www.cms.hhs.gov/MedicaidDrugRebateProgram/10_DrugComContactInfo.asp

(6) Clozaril/Clozapine therapy:

(a) Clozapine is covered only for the treatment of clients who have failed therapy with at least two anti-psychotic medications;

(b) Clozapine supervision is the management and record keeping of clozapine dispensing as required by the manufacturer of clozapine. This is part of an evaluation and management service conducted by the appropriately licensed prescribing medical practitioner;

(c) Pharmacies dispensing clozapine shall comply with OAR 410-121-0190. Stat. Auth. 413.042

Stats. Implemented: ORS 414.025 and 414.065

410-130-0190 – Tobacco Cessation

(1) Tobacco treatment interventions may include one or more of these services: basic, intensive, and telephone calls.

(2) Basic tobacco cessation treatment includes the following services:

(a) Ask -- systematically identify all tobacco users -- usually done at each visit;

(b) Advise -- strongly urge all tobacco users to quit using;

(c) Assess – the tobacco user's willingness to attempt to quit using tobacco within 30 days;

(d) Assist -- with brief behavioral counseling, treatment materials and the recommendation/prescription of tobacco cessation therapy products (e.g., nicotine patches, oral medications intended for tobacco cessation treatment and gum);

(e) Arrange -- follow-up support and/or referral to more intensive treatments, if needed.

(3) When providing basic treatment, include a brief discussion to address client concerns and provide the support, encouragement, and counseling needed to assist with tobacco cessation efforts. These brief interventions, less than 6 minutes, generally are provided during a visit for other conditions, and additional billing is not appropriate.

(4) Intensive tobacco cessation treatment is on the Health Services Commission's Prioritized List of Health Services and is covered if a documented quit date has been established. This treatment is limited to ten sessions every three months. Treatment is reserved for those clients who are not able to quit using tobacco with the basic intervention measures.

(5) Intensive tobacco cessation treatment includes the following services:

(a) Multiple treatment encounters (up to ten in a 3 month period);

(b) Behavioral and tobacco cessation therapy products (e.g., nicotine patches, oral medications intended for tobacco cessation treatment and gum);

(c) Individual or group counseling, six minutes or greater.

(6) Telephone calls: the Division may reimburse a telephone call intended as a replacement for face-to-face contact with clients who are in intensive treatment as it is considered a reasonable adjunct to, or replacement for, scheduled counseling sessions:

(a) The call must last six to ten minutes and provides support and follow-up counseling;

(b) The call must be conducted by the provider or other trained staff under the direction or supervision of the provider;

(c) Enter proper documentation of the service in the client's chart.

(7) Diagnosis Code ICD-9-CM 305.1 (Tobacco Use Disorder):

(a) Use as the principal diagnosis code when the client is enrolled in a tobacco cessation program or if the primary purpose of the visit is for tobacco cessation services;

(b) Use as a secondary diagnosis code when the primary purpose of this visit is not for tobacco cessation or when the tobacco use is confirmed during the visit.

(8) Billing Information: Managed care plans may have tobacco cessation services and programs. This rule does not limit or prescribe services a Prepaid Health Plan provides to clients receiving the Basic Health Care Package.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-130-0200 – Prior Authorization (T)

(1) For fee-for-service (FFS) clients, prior authorization (PA) is required for all procedure codes listed in Table 130-0200-1 regardless of the setting in which they are performed. For details on where to obtain PA, download a copy of the Medical-Surgical Services Supplemental Information booklet at:
http://www.dhs.state.or.us/policy/healthplan/guides/medsurg/med-surgsupp0912.pdf

(2) For clients enrolled in a prepaid health plan (PHP), providers must obtain PA from the client's PHP.

(3) The Division shall authorize for the level of care or type of service that meets the client's medical need consistent with the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List) and guideline notes, as referenced in OAR 410-141-0520.

(4) Codes for which medical need has not been specified by the HERC shall be authorized based on medical appropriateness as the term is defined in OAR 410-120-0000.

(5) For bariatric surgery, PA is required in two steps from:

(a) The OHP primary care provider prior to referral to a bariatric surgery center, and

(b) The bariatric surgery center prior to surgery.

(6) PA is not required:

(a) For clients with both Medicare and Medical Assistance Program coverage, and the service is covered by Medicare. However, PA is still required for bariatric surgeries and evaluations and most transplants, even if they are covered by Medicare;

(b) For kidney and cornea transplants unless they are performed out-of-state;

(c) For emergent or urgent procedures or services;

(d) For hospital admissions unless the procedure requires PA.

(7) A second opinion may be requested by the Division or the contractor before PA is given for a surgery.

(8) Treating and performing practitioners are responsible for obtaining PA.

(9) Refer to Table 130-0200-1 for all services and procedures requiring PA.

(10) Table 130-0200-1

Statutory Authority: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

Table 130-0200-1 Prior Authorization

For numbers followed by (*#):
(*1) Authorized for facial lesions only, if meets other PA requirements (*2) PA not required for clients under age 21

00580	21183	22614	27447	38207
00796	21184	22630	28340	38208
00938	21188	22632	28341	38209
01990	21193	22633	28344	38210
11960	21194	22634	28345	38211
11970	21195	22800	29800	38212
15822	21196	22802	30400	38213
15823	21198	22804	30410	38214
17106	21199	22808	30420	38215
17107	21206	22810	30430	38230
17108	21208	22812	30435	38240
20910	21209	22818	30450	38241
21050	21256	22819	30460	38243
21120	21260	22840	30462	40840
21121	21261	22841	32851	40842
21137	21263	22842	32852	40843
21138	21267	22843	32853	40844
21139	21268	22844	32854	40845
21141	21270	22845	32855	41899
21142	21275	22846	32856	42820
21143	21280	22847	33933	42821
21145	22532	22848	33935	42825
21146	22534	22849	33944	42826
21147	22548	22851	33945	42830
21150	22551	22856	33976	42831
21151	22552	22857	33979	42835
21154	22554	22861	33981	42836
21155	22556	22862	33982	43631
21159	22558	22864	33983	43632
21160	22585	22865	33990	43633
21172	22586	23472	33991	43634
21175	22590	23473	33992	43641
21179	22595	23474	33993	43644
21180	22600	26560	38204	43645
21181	22610	26561	38205	43770
21182	22612	26562	38206	43771

43773	54400	58543	63057	63271
43775	54401	58544	63064	63272
43842	54405	58548	63066	63273
43843	54408	58550	63075	63275
43846	54410	58552	63076	63276
43847	54411	58553	63077	63277
43848	54416	58554	63078	63278
44135	54417	58570	63081	63280
44715	55970	58571	63082	63281
44720	55980	58572	63085	63282
44721	56805	58573	63086	63282
47135	57267	58660	63087	63285
47136	57283	58661	63088	63286
47140	57284	58672	63090	63287
47141	57288	58673	63091	63290
47142	57291	58720	63101	63295
47143	57292	58940	63102	63300
47144	57335	62351	63103	63301
47145	58150	63001	63170	63302
47146	58152	63003	63172	63303
47147	58180	63005	63173	63304
47562	58200	63011	63180	63305
47563	58210	63012	63182	63306
47564	58240	63015	63185	63307
47570	58260	63016	63190	63308
47600	58262	63017	63191	63295
47605	58263	63020	63194	65125
47610	58267	63030	63195	65130
47612	58270	63035	63196	65135
47620	58275	63040	63197	65140
48160	58280	63042	63198	65150
48551	58285	63043	63199	65155
48552	58290	63044	63200	67311
48554	58291	63045	63250	67312
48556	58292	63046	63251	67314
49000	58293	63047	63252	67316
49329	58294	63048	63265	67318
51840	58400	63050	63266	67320
51841	58410	63051	63267	67331
51845	58541	63055	63268	67332
54360	58542	63056	63270	67334

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410-130-0220 – Not-Covered/Bundled Services (T)

(1) Refer to the Oregon Health Plan administrative rules (chapter 410, division 141) and General Rules (chapter 410, division 120) for coverage of services. Refer to Table 130-0220-1 in this rule for additional information regarding not covered services or for services that the Division of Medical Assistance Programs (Division) considers to be bundled in other services.

(2) The following are examples of not covered services. This is not an all-inclusive list:

(a) Psychotherapy services (covered only through local mental health clinics and Mental Health Organizations);

(b) Routine postoperative visits (included in the payment for the surgery) during 90 days following major surgery (global period) or 10 days following minor surgery.

(c) Services that are normally provided in the practitioner's office but at the client's request are provided in a location other than the practitioner's office.

(d) Telephone calls for purposes other than tobacco cessation, maternity case management and telemedicine.

(3) For specific information, see General Rules OAR 410-120-1200, Medical Assistance Benefits: Excluded Services and Limitations.

(4) Table 130-0220-1

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Table 130-0220-1 – Not Covered/Bundled Services

0001F-7025F	29914-29916	45391
0019T-0259T	31620	45392
802	31627	46505
11920-11922	32491	47133 BND
11980	32850 BND	48550 BND
15819-15821	32998	50380
15824-15826	33140	50592
15847	33141	50593
15928	33282	52010
15929	33548	58345
19316	33930 BND	53850
20696	33940 BND	53852
20697	36455	53860
20979	37210	55300-55873
20982	38129	58321-58323
21685	41530	58345
22520-22525	41821	58350
22856	43257	58672
22857	43647	58740 BND
22861	43648	58750
22862	43842	58752
22864	43843	58760
22865	43881	58825
27080	43882	58970
27418	43886-43888	58974
28890	44132 BND	84431
29866-29868	44133 BND	84830
58976	75571	86305

410-130-0225 – Teaching Physicians

(1) Supervising faculty physicians in a teaching hospital may not bill the Division of Medical Assistance Programs (Division) on a CMS1500 or 837P when serving as an employee of the hospital during the time the service was provided or when the hospital reports the service as a direct medical education cost on the Medicare and Division cost report.

(2) For requirements for the provision of services, including documentation requirements, follow Medicare guidelines for Teaching Physician Services.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-130-0230 – Administrative Medical Examinations and Reports

(1) This rule does not apply to Managed Health Care plans.

(2) These services are covered only when requested by a CAF, SPD, AMH, OYA, SCF branch office or approved by the Division of Medical Assistance Programs (Division). The branch office may request an administrative medical examination or a medical report (DMAP 729) to establish client eligibility for an assistance program or casework planning.

(3) See the Administrative Examination and Report Billing rule for complete billing instructions.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-130-0240 – Medical Services

(1) Coverage of medical and surgical services is subject to the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List). Medical and surgical services requiring prior authorization (PA) are listed in Oregon administrative rule (OAR or rule) 410-130-0200, PA Table 130-0200-1, and medical and surgical services that are Not Covered/Bundled services are listed in OAR 410-130-0220, Table 130-0220-1.

(2) Coverage for acupuncture services by an enrolled acupuncture provider are subject to the HERC Prioritized List and the client's benefit plan.

(3) Coverage for medically appropriate chiropractic services provided by an enrolled chiropractor is subject to the HERC Prioritized List and benefit plan for:

(a) Diagnostic visits including evaluation and management services;

(b) Chiropractic care including manipulative treatment;

(c) Laboratory and radiology services.

(4) Maternity care and delivery:

(a) The Division may consider payment for delivery within a hospital, clinic, birthing center, or home setting;

(b) For out-of-hospital births, the Division may only consider payment for labor and delivery care of women experiencing low risk pregnancy. The Division will determine whether a pregnancy can be considered low risk and an out-of-hospital birth is eligible for payment;

(c) The Division adopts Table I from OAR 333-076-0650 to outline the absolute risk factors that, if present, would preclude payment for initiation or continuation of any out-of-hospital labor and delivery care. For a planned out-of-hospital birth, the Division requires that a contingency for an in-hospital birth be included in the medical record. The division considers all conditions listed in Table I of OAR 333-076-0650 to necessitate an in-hospital birth if present or anticipated to be present at the onset of labor. The Division may deny payment for labor and delivery services in an out-of-hospital setting if it determines that an in-hospital birth was necessary and appropriate steps to facilitate an in-hospital birth were not pursued. When an in-hospital birth becomes necessary for a client that was seeking a planned out-of-hospital birth and care is transferred from one provider to another, the Division will consider payment for both providers for the portion of care provided. Bill using appropriate CPT and HCPCS codes.

(d) When a provider is practicing within the authorization of his or her license, the division may consider payment for administration of drugs and devices that are used in pregnancy, birth, postpartum care, newborn care, or resuscitation and that are deemed integral to providing safe care.

(e) For out-of-hospital births, drugs authorized in subsection (d) or this section are limited:

(A) For out-of-hospital births, the Division will make no payment for general, spinal, caudal, or epidural anesthesia administered for care associated with labor and delivery;

(B) For out-of-hospital births, the Division will make no payment for inducing, stimulating, or using chemical agents to augment labor during the first or second stages of labor;

(C) For out-of-hospital births, the Division will consider payment for chemical agents administered to inhibit labor only as a temporary measure until referral or transfer of the client to a higher level of care is complete.

(f) Within the home setting, the Division may consider payment for appropriate supplies in addition to delivery payment. The additional payment for supplies includes all supplies, equipment, staff assistance, and newborn screening cards;

(g) During labor in an out-of-hospital setting, should any of the risk factors outlined in Table II of OAR 333-076-0650 develop, the Division requires that the client will be transferred to a hospital, and the Division may deny payment for labor and delivery services if it determines that appropriate steps to facilitate the transfer were not pursued. Appropriate transfer of care must be in accordance with the practitioner's licensure requirements. When labor management does not result in a delivery, and the client is appropriately transferred to a higher level of care, the provider shall code for labor management only. Bill code 59899 and attach appropriate clinical documentation of services performed with respect to labor management;

(h) For births in an out-of-hospital setting, should any of the risk factors outlined in Table III of OAR 333-076-0650 develop during the postpartum period in the mother or infant, the Division requires that the client will be transferred to a hospital, and the Division may deny payment for labor and delivery services if it determines that appropriate steps to facilitate the transfer were not pursued. Appropriate transfer of care must be in accordance with the practitioner's licensure requirements. The Division will consider payment for both providers for the portion of care provided when appropriate;

(i) For multiple vaginal births, use the appropriate CPT code for the first delivery. Use the delivery-only code for the subsequent deliveries. The Division will reimburse the first delivery at 100 percent and the subsequent deliveries at 50 percent of the

delivery-only code's maximum allowance. For multiple babies delivered via cesarean section, the Division pays for the cesarean section only once.

(5) Neonatal Intensive Care Unit (NICU) procedures:

(a) Are reimbursed only to neonatologists and pediatric intensivists for services provided to infants when admitted to a Neonatal or Pediatric Intensive Care Unit (NICU/PICU). All other pediatricians must use other CPT codes when billing for services provided to neonates and infants;

(b) Neonatal intensive care codes are not payable for infants on Extracorporeal Membrane Oxygenation (ECMO). Use appropriate CPT ECMO codes.

(6) Neurology or Neuromuscular payment for polysomnograms and multiple sleep latency tests (MSLT) are each limited to two in a 12-month period.

(7) Oral health services provided by medical practitioners may include an oral assessment and application of topical fluoride varnish during a medical visit for children. Refer to OAR 410-123-1260 Dental Services program rule.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-130-0245 – Early and Periodic Screening, Diagnostic and Treatment Program

(1) The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, formerly called Medicheck, offers "well-child" medical exams with referral for medically appropriate comprehensive diagnosis and treatment for all children (birth through age 20) covered by the Oregon Health Plan (OHP) Plus benefit package.

(2) Screening Exams:

(a) Physicians (MD or DO), nurse practitioners, licensed physician assistants and other licensed health professionals may provide EPSDT services. Screening services are based on the definition of "Preventive Services" in OHP OAR 410-141-0000, Definitions;

(b) Periodic EPSDT screening exams must include:

(A) A comprehensive health and developmental history including assessment of both physical and mental health development;

(B) Assessment of nutritional status;

(C) Comprehensive unclothed physical exam including inspection of teeth and gums;

(D) Appropriate immunizations;

(E) Lead testing for children under age 6 as required. See the "Blood Lead Screening" section of this rule;

(F) Other appropriate laboratory tests (such as anemia test, sickle cell test, and others) based on age and client risk;

(G) Health education including anticipatory guidance;

(H) Appropriate hearing and vision screening.

(c) The provider may bill for both lab and non-lab services using the appropriate Current Procedural Terminology (CPT) and Health care Common Procedure Coding System (HCPCS) codes. Immunizations must be billed according to the guidelines listed in OAR 410-130¬0255;

(d) Inter-periodic EPSDT screening exams are any medically appropriate encounters with a physician (MD or DO), nurse practitioner, licensed physician assistant, or other licensed health professional within their scope of practice.

(3) Referrals:

(a) If, during the screening process (periodic or inter-periodic), a medical, mental health, substance abuse, or dental condition is discovered, the client may be referred to medical providers, Addictions and Mental Health Division (AMH), or dental providers for further diagnosis and/or treatment;

(b) The screening provider shall explain the need for the referral to the client, client's parent, or guardian;

(c) If the client, client's parent, or guardian agrees to the referral, assistance in finding an appropriate referral provider and making an appointment should be offered;

(d) The caseworker or local branch will assist in making other necessary arrangements.

(4) Blood Lead Screening: All children ages 12 months to 72 months are considered at risk for lead poisoning. Children ages 12 months to 72 months with Medical Assistance Program coverage must be screened for possible exposure to lead poisoning. Because the prevalence of lead poisoning peaks at age two, children screened or tested at age one should be re-screened or re-tested at age two. Screening consists of a Lead Risk Assessment Questionnaire (DMAP form 9033) and/or blood lead tests as indicated.

(5) Lead Risk Assessment Questionnaire: Complete the Lead Risk Assessment Questionnaire (DMAP form 9033) found in the Medical-Surgical Services Supplemental Information. Beginning at 1 year of age, the questionnaire must be used at each EPSDT exam to assess the potential for lead exposure. Retain this questionnaire in the client's medical record. Do not attach the DMAP 9033 form to the claim for reimbursement. The Division does not stock this form; photocopy the form and the instructions from the Medical-Surgical Services Supplement Information.

(6) Blood Lead Testing: Any "yes" or "don't know" answer in Part B, questions 1-8 on the Lead Risk Assessment Questionnaire (DMAP 9033) means that the child should receive a screening blood lead test. An elevated blood lead level is defined as greater than or equal to 10 µg/dL. Children with an elevated blood lead screening test should have a confirmatory blood lead test performed according to the schedule described in Table 130-0245-1 of this rule. If the confirmatory blood lead test is elevated, follow-up blood lead tests should be performed approximately every three months until two consecutive test results are less than 10 µg/dL. Comprehensive follow-up services based on the results of the confirmatory blood lead test are described in Table 130-0245-2 and section (7) of this rule.

(7) Children with a confirmatory blood lead level test of greater than or equal to 10 µg/dL are eligible for a one-time comprehensive environmental lead investigation, not including laboratory analysis, of the child’s home. The child may also receive follow-up case management services.

(a) The investigation of the child's home and follow-up case management services must be provided by a Division-enrolled medical-surgical provider who has received Oregon Public Health Division training to perform these services. Refer to Medical-Surgical Services rule 410-130-0000 for a list of the medical-surgical providers the Division enrolls.

(b) To bill for these services, use HCPCS code T1029. Payment for code T1029 includes the home investigation and any follow-up case management services provided after the home investigation is completed. The Division limits reimbursement of T1029 to one time per dwelling. For clients enrolled in managed care plans, the service is payable by the Division; do not bill the managed care plan.

(8) Method of Blood Collection: Either venipuncture or capillary draw is acceptable for the screening blood lead test. All confirmatory blood lead tests must be obtained by venipuncture. Erythrocyte protoporphyrin (EP) testing is not a substitute for either a screening or a confirmation blood lead test.

(9) Additional Lead-Related Services: Families should be provided anticipatory guidance and lead education prenatally and at each well-child visit, as described in Tables 130-0245-3 and 130-0245-4 of this rule.

(10) Table 130-0245-1

(11) Table 130-0245-2

(12) Table 130-0245-3

(13) Table 130-0245-4

(14) Table 130-0245-5

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.150

Table 130-0245-1 – Schedule For Confirmatory Testing

The following is the schedule for confirmatory testing of a child with an elevated Blood Lead Level (BLL) on a screening test. Providers should refer to current Oregon Public Health Division guidance.

Screening test (µg/dL) result is:	**Perform confirmatory test on venous blood within:**
10- 19	30 days
20-44	7 days*
45-59	48 hours
60-69	24 hours
≥70	Immediately as an emergency lab test

*The higher the screening BLL, the more urgent the need for confirmatory testing.

Blood lead level (BLL) – the concentration of lead in a sample of blood. This concentration is usually expressed in micrograms per deciliter (µg/dL).

Confirmatory testing – the first venous (venipuncture) blood lead test performed within 6 months on a child who has previously had an elevated BLL on a screening test.

Table 130-0245-2 – Comprehensive Follow-up Services

Confirmatory BLL (µg/dL)	Action
<10	Reassess or re-screen in one year. No additional action necessary unless exposure sources change.
10-14	Provide family lead education (See Table 130-0245¬4). *Provide follow-up testing. Refer for social services, if necessary.
15-19	Provide family lead education. See Table 130-0245-4. *Provide follow-up testing. Refer for social services, if necessary. If elevated BLLs persist (i.e., 2 venous elevated BLLs in this range at least 3 months apart) or worsen, proceed according to actions for elevated BLLs 20-44.
20-44	Provide coordination of care (case management). Provide clinical management (See Table 130-0245-5). Provide environment investigation. Provide lead-hazard control.
45-69	Within 48 hours, begin coordination of care (case management), clinical management (See Table 130-0245¬5), environmental investigation, and lead hazard control.
>70	Hospitalize child and begin medical treatment immediately. Begin coordination of care (case management), clinical management (See Table 130¬0245-5), environmental investigation, and lead-hazard control immediately.

*Follow-up testing, after a confirmatory test result of 10 µg/dL, should be every 3 months until two consecutive test results are each < 10 µg/dL.

Table 130-0245-3 – Anticipatory Guidance

Anticipatory guidance should be provided prenatally, and at every well-child visit, beginning at one year of age.

Parental guidance at these times might prevent some lead exposure and the resulting increase in BLLs that often occurs during a child's second year of life.

When children are 1-2 years of age, parental guidance should be provided at well-child visits and when the Lead Screening/Testing Questionnaire (DMAP 9033) is administered.

Give anticipatory guidance at each prenatal and well-child visit, provide information about:

- Hazards of lead-based paint in homes built before 1950.
- Methods of controlling lead hazards safely.
- Hazards associated with repainting and renovation of homes built prior to 1978.
- Other exposure sources, such as traditional remedies.

Table 130-0245-4 – Family Lead Education

Provide families of children with capillary or venous BLLs >10 µg/dL with prompt and individualized education about the following:

Their child's BLL, and what it means.

Potential adverse health effects of an elevated blood lead level (EBLL).

Sources of lead exposure and suggestions on how to reduce exposure.

Importance of wet cleaning to remove lead dust on floors, windowsills, and other surfaces; the ineffectiveness of dry methods of cleaning, such as sweeping.

Importance of good nutrition in reducing the absorption and effects of lead. If there are poor nutritional patterns discuss adequate intake of calcium and iron and encourage regular meals.

Need for follow-up BLL testing to monitor the child's BLL, as appropriate.

Results of the environmental inspection, if applicable, will be mailed to the health-care provider and the family by the local health department.

Hazards of improper removal of lead-based paint. Particularly hazardous are open-flame burning, power sanding, water blasting, methylene chloride-based stripping, and dry sanding and scraping.

Family lead education should be reinforced during follow-up visits, as needed. The LeadLine can furnish educational materials to the health-care provider, including printed materials in various languages.

Table 130-0245-5 – Clinical Management

Clinical management is part of comprehensive follow-up care and is defined as the care that is usually given by a health-care provider to a child with an elevated BLL.

Office visits for clinical management should be accompanied by activities that take place in the child's home, such as home visits by a nurse, social worker, or community health worker, environmental investigations; and control of lead hazards identified in the child's environment.

Provide clinical management for children when appropriate. Clinical management includes:

- Clinical evaluation for complications of lead poisoning.
- Family lead education and referrals.
- Chelation therapy, if appropriate.
- Follow-up testing at appropriate intervals.

Recommendations about clinical management are based on the experience of clinicians who have treated lead-poisoned children. They should not be seen as rigid rules and should be used to rule clinical decisions.

410-130-0255 – Immunizations, Vaccines for Children, and Immune Globulins

(1) The Division of Medical Assistance Programs (Division) covers immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Oregon Immunization Program. The approved ACIP recommendations are found in Guideline Note 106 of the Health Evidence Review Commission's Prioritized List of Health Services as referenced in OAR 410-141-0520, http://www.oregon.gov/oha/OHPR/pages/herc/current-prioritized-list.aspx .

(2) Providers shall follow the (ACIP) guidelines for immunization schedules. Exceptions include:

(a) On a case-by-case basis, provider may use clinical judgment in accordance with accepted medical practice to provide immunizations on a modified schedule, and;

(b) On a case-by-case basis, provider may modify immunization schedule in compliance with the laws of the State of Oregon, including laws relating to medical and non-medical exemptions for immunizations.

(3) Providers are encouraged to administer combination vaccines when medically appropriate and cost effective.

(4) Providers must use standard billing procedures for adults and for any vaccines that are not part of the Vaccines for Children (VFC) Program.

(5) Vaccines for Children (VFC) is a federal program that provides vaccine serums at no cost to providers for clients ages 0 through 18. All vaccines for this age group and for conditions covered by the VFC program must be obtained through the VFC program. The Division will not reimburse providers for the administration or purchase of privately purchased vaccines if the vaccine could have been obtained through the VFC program. For information about the VFC program or to enroll as a VFC provider, contact the Public Health Immunization Program. The Oregon VFC program website can be located at
http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/vfc/Pages/index.aspx

(6) The Division will only reimburse for the administration, not the serum, of vaccines available for free through the VFC Program. Refer to the 12/24/2013 Current Oregon Immunization Program State-Supplied Vaccine Billing Codes table available at http://bit.ly/1c3T6zy for a list of vaccines provided through the VFC Program.

(7) To receive reimbursement for vaccine administration, VFC program providers must bill the Division:

(a) With the appropriate vaccine common procedural terminology (CPT) code included;

(b) Including the appropriate modifier -SL or -26; and

(c) Reporting the vaccine administration in addition to an Evaluation and Management service (e.g., well-child visit) if provided on the same date of service;

(8) For clients with private insurance, providers may bill the Division or the client's managed care or coordinated care organization (MCO/CCO) directly for the administration of VFC vaccines. Medicaid and CHIP are not considered the "payer of last resort" for administration of VFC vaccines.

(9) In compliance with Section 1202 of the Affordable Care Act ,VFC providers who qualify for the federal primary care rate increase as specified under 42 Code of Federal Regulation (CFR) 447 Subpart G (see also OAR 410-130-0005) are eligible for reimbursement for the administration of VFC vaccines at the Regional Maximum amount:

(a) Effective 1/1/2013 the Regional Maximum amount is $21.96.

(b) For providers that have met the federal primary care definition, MCO and CCOs are required to reimburse the lessor of:

(A) The Regional Maximum administration fee, or

(B) Medicare 2014 RVU and 2009 conversion factor amount.

(c) MCO and CCOs are not required to reimburse the Regional Maximum amount to providers that have not met the federal primary care definition but may at their option.

(d) For all fee for service providers, the Division reimburses the Regional Maximum amount for the administration of VFC vaccines.

(10) The Division covers immune globulins based on the Prioritized List of Health Services. Synagis (palivizumab-rsv-igm) is covered with prior authorization only for high-risk infants and children. Refer to Guideline Note 69 of the Health Evidence Review Commission's List of Prioritized Services as referenced in OAR 410-141-0520, http://www.oregon.gov/oha/OHPR/pages/herc/current-prioritized-list.aspx and Oregon Medicaid Fee-For-Service Prior Authorization Approval Criteria as referenced in OAR 410-121-0040, http://www.dhs.state.or.us/policy/healthplan/guides/pharmacy/clinical.html#pa.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-130-0365 – Ambulatory Surgical Center and Birthing Center Services

(1) Ambulatory Surgical Centers (ASC) and Birthing Centers (BC) must be licensed by the Oregon Health Division. ASC and BC services are items and services furnished by an ASC or BC in connection with a covered surgical procedure as specified in the Division of Medical Assistance Programs' Medical-Surgical Services or Dental Services rules. Reimbursement is made at all-inclusive global rates based on the surgical procedure codes billed.

(2) If the client has Medicare in addition to Medicaid and Medicare covers a surgery, but not in an ASC setting, then the surgery may not be performed in an ASC.

(3) Global rates include:

(a) Nursing services, services of technical personnel, and other related services;

(b) Any support services provided by personnel employed by the ASC or BC facility;

(c) The client's use of the ASC's or BC's facilities including the operating room and recovery room;

(d) Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment related to the provision of the surgical procedure(s);

(e) Diagnostic or therapeutic items and services related to the surgical procedure;

(f) Administrative, record-keeping, and housekeeping items and services;

(g) Blood, blood plasma, platelets;

(h) Materials for anesthesia;

(i) Items not separately identified in section (4) of this rule.

(4) Items and services not included in ASC or BC Global Rate:

(a) Practitioner services such as those performed by physicians, licensed physician assistants, nurse practitioners, certified registered nurse anesthetists, dentists, podiatrists and Licensed Direct Entry Midwives (for birthing centers only);

(b) The sale, lease, or rental of durable medical equipment to ASC or BC clients for use in their homes;

(c) Prosthetic and orthotic devices;

(d) Ambulance services;

(e) Leg, arm, back and neck brace, or other orthopedic appliances;

(f) Artificial legs, arms, and eyes;

(g) Services furnished by a certified independent laboratory.

(5) ASCs and BCs will not be reimbursed for services that are normally provided in an office setting unless the practitioner has justified the medical appropriateness of using an ASC or BC through documentation submitted with the claim. Practitioner's justification is subject to review by the Division If payment has been made and the practitioner fails to justify the medical appropriateness for using an ASC or BC facility, the amount paid is subject to recovery by the Division.

(6) Procedure coding for non-Birthing Centers:

(a) Bill the same procedure codes billed by the surgeon;

(b) For reduced or discontinued procedures, use Common Procedural Terminology (CPT) instructions and add appropriate modifiers;

(c) Attach a report to the claim when billing an unlisted code;

(d) For billing instructions regarding multiple procedures, see rule 410-130-0380.

(7) Procedure coding for Birthing Centers:

(a) Bill code 59409 only once for a single vaginal delivery regardless of the total days that the client was in the facility for labor management, delivery and immediate postpartum care;

(b) For delivery of twins:

(A) Bill the delivery of the first twin with 59409; and

(B) Bill the delivery of the second twin with code 59409 on a separate line;

(c) When labor was managed in the BC but a delivery did not result, bill S4005 (Interim labor facility global) and attach a report documenting the circumstances.

(8) Prior authorization is required for all services listed in Table 1300200-1. Refer to Rule 410-130-0200.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

410-130-0368 – Anesthesia Services

(1) Anesthesia is not covered for procedures that are below the funding line on the Health Services Commission's Prioritized List of Health Services (see OAR 410-141-0520).

(2) Effective January 1, 2012 all anesthesia claims submitted must be billed in minutes only. This includes;

(a) Claims for services provided prior to 1/1/12 that are submitted for the first time in 2012;

(b) Resubmitted unpaid claims for services provided prior to 1/1/12; and

(c) Adjustments made to claims for services performed prior to 1/1/12. Units must be converted by the provider from units to minutes.

(3) Qualifier MJ (indicating minutes) must be added to all claims;

(a) Claims with qualifier UN (indicating units) will be denied; and

(b) Claims without a qualifier will be denied.

(4) Reimbursement is based on the base units assigned to each anesthesia code listed in the current American Society of Anesthesiology Relative Value Guide plus one unit per each 15 minutes of anesthesia time, except for anesthesia for neuraxial labor analgesia/anesthesia/anesthesia (code 01967). See (5) below for reimbursement of neuraxial labor analgesia/anesthesia.

(a) The Division of Medical Assistance Programs (Division) will automatically calculate payment by adding the base units of the billed anesthesia code plus a unit per each 15 minutes of anesthesia time;

(b) Reimbursement will be made at a fraction of a unit for the last 1-14 minutes of anesthesia time;

(c) Do not add base units in addition to minutes.

(5) Anesthesia for neuraxial labor analgesia/anesthesia (code 01967) will be paid at a flat rate regardless of the units billed.

(6) Reimbursement for qualifying circumstances codes 99100-99140 and modifiers P1-P6 is bundled in the payment for codes 00100-01999. Do not add charges for 99100-99140 and modifiers P1-P6 in charges for 0010001999.

(7) A valid consent form is required for all hysterectomies and sterilizations.

(8) If prior authorization (PA) was not obtained for a procedure that requires PA, then the anesthesia services may not be paid. Refer to OAR 410-1300200 PA Table 130-0200-1.

(9) Anesthesia services are not payable to the provider performing the surgical procedure except for moderate (conscious) sedation.

(10) Moderate (conscious) sedation must be billed with codes 9914399150.

Statutory Authority: ORS Chapter 413.042

Statutes Implemented: 414.025 and 414.065

410-130-0380 – Surgery Guidelines

(1) The Division of Medical Assistance Programs (Division) reimburses all covered surgical procedures as global packages. Global payments do not include initial consultation or evaluation of the problem by the surgeon to determine the need for surgery.

(2) Surgical procedures listed in the Medical-Surgical Services administrative rules with prior authorization (PA) indicated require authorization unless they are emergent.

(3) Global payment for major surgery includes:

(a) Surgery;

(b) Pre-operative visits within 15 days of the surgery (except the initial consultation);

(c) Initial admission history and physical;

(d) Related follow-up visits within 90 days after the surgery;

(e) Treatment of complications not requiring a return trip to the operating room;

(f) Hospital discharge.

(4) Global payment for minor surgery includes:

(a) Surgery;

(b) Pre-operative visits within 15 days of the surgery;

(c) Initial admission history and physical;

(d) Related follow-up visits for 10 days after the surgery;

(e) Hospital discharge.

(5) Global payment for endoscopy includes:

(a) Surgery;

(b) Related visit on the same day as the endoscopy procedure;

(c) No follow-up days for this procedure;

(d) Pre-operative and post-operative care provided by the surgeon's associate(s) or by another physician "on call" for the surgeon are considered included in the

reimbursement to the surgeon and will not be paid in addition to the payment to the surgeon;

(e) Do not bill separately for procedures which are considered to be bundled in another procedure. Payment for bundled services is included in the primary surgery payment.

(6) Co-surgeons -- Two or more surgeons/same or different specialties/separate functions/one major or complex surgery:

(a) Add modifier -62 to procedure code(s);

(b) Payment will be determined by medical review.

(7) Team Surgeons -- Two or more surgeons/different specialties performing/separate surgeries/same operative session:

(a) Add modifier -66 to procedure code(s);

(b) Payment will be determined by medical review.

(8) Multiple Surgical Procedures performed during the same operative session:

(a) Primary Procedure paid at 100% of the Division maximum fee for that procedure;

(b) Second and third procedure paid at 50% of the Division maximum fee;

(c) Fourth, fifth, etc. paid at 25% or less as determined by the Division;

(d) Endoscopic procedures paid at 100% of the Division maximum fee for the primary level procedure. The Division fee for insertion will be deducted from the maximum allowable for each additional procedure performed at the same site;

(e) Bill each procedure on separate lines (even multiples of the same procedure) unless the code description specifies "each additional";

(f) Bilateral procedures must be billed on two lines unless a single code identifies a bilateral procedure. Use modifier -50 only on the second line;

(g) Reimbursement for laparotomy is included in the surgical procedure and should not be billed separately or in addition to the surgical procedure;

(h) For Integumentary System codes 10000 thru 17999, bill multiples of the same procedure on the same line with the appropriate quantity unless the code indicates the first in a series (i.e., code 11100) or the code is for multiple procedures (i.e., code 11900).

(9) Surgical Assistance -- Payment is restricted to physicians, naturopaths, podiatrists, dentists, nurse practitioners, licensed physician assistants, and registered nurse first assistants:

(a) The assistance must be medically appropriate;

(b) No payment will be made for surgical assistant for minor surgical or diagnostic procedures, e.g., "scoping" procedures;

(c) Only one surgical assistant may receive payment (except when the need is clinically documented);

(d) Use an appropriate modifier to indicate assistance.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-130-0562 – Abortion

(1) For medically induced abortions by oral ingestion of medication use S0199 for all visits, counseling, lab tests, ultrasounds, and supplies. S0199 is a global package except for medication:

(2) Bill medications with codes S0190-S0191 and appropriate HCPCS codes.

(3) For surgical abortions use CPT codes 59840 through 59857:

(4) .For services related to surgical abortion such as lab, ultrasound and pathology bill separately. Add modifier U4 (a Division of Medical Assistance Programs (Division) modifier) for surgical abortion related services.

(5) Use the most appropriate ICD-9 diagnosis code.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.125, 414.065

410-130-0580 – Hysterectomies and Sterilization

(1) Refer to OAR 410-130-0200 Prior Authorization, Table 130-02001 and OAR 410-130-0220 Not Covered/Bundled Services, Table 1300220-1.

(2) Hysterectomies performed for the sole purpose of sterilization are not covered.

(3) All hysterectomies, except radical hysterectomies, require prior authorization (PA).

(4) A properly completed Hysterectomy Consent form (DMAP 741) or a statement signed by the performing physician, depending upon the following circumstances, is required for all hysterectomies:

(a) When a woman is capable of bearing children:

(A) Prior to the surgery, the person securing authorization to perform the hysterectomy must inform the woman and her representative, if any, orally and in writing, that the hysterectomy will render her permanently incapable of reproducing;

(B) The woman or her representative, if any, must sign the consent form to acknowledge she received that information.

(b) When a woman is sterile prior to the hysterectomy, the physician who performs the hysterectomy must certify in writing that the woman was already sterile prior to the hysterectomy and state the cause of the sterility;

(c) When there is a life-threatening emergency situation that requires a hysterectomy in which the physician determines that prior acknowledgment is not possible, the physician performing the hysterectomy must certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible and describe the nature of the emergency.

(5) In cases of retroactive eligibility: The physician who performs the hysterectomy must certify in writing one of the following:

(a) The woman was informed before the operation that the hysterectomy would make her permanently incapable of reproducing;

(b) The woman was previously sterile and states the cause of the sterility;

(c) The hysterectomy was performed because of a life-threatening emergency situation in which prior acknowledgment was not possible and describes the nature of the emergency.

(6) Do not use the Consent to Sterilization form (DMAP 742A or B) for hysterectomies.

(7) Submit a copy of the Hysterectomy consent form with the claim.

(8) Sterilization Male & Female: A copy of a properly completed Consent to Sterilization form (DMAP 742 A or B), the consent form in the federal brochure DHHS Publication No. (05) 79-50062 (Male), DHHS Publication No. (05) 79-50061 (Female) or another federally approved form must be submitted to the Division for all sterilizations. The original consent form must be retained in the clinical records. Prior authorization is not required.

(9) Voluntary Sterilization:

(a) Consent for sterilization must be an informed choice. The consent is not valid if signed when the client is:

(A) In labor;

(B) Seeking or obtaining an abortion; or

(C) Under the influence of alcohol or drugs.

(b) Ages 15 years or older who are mentally competent to give informed consent:

(A) At least 30 days, but not more than 180 days, must have passed between the date of the informed written consent (date of signature) and the date of the sterilization except:

(i) In the case of premature delivery by vaginal or cesarean section the consent form must have been signed at least 72 hours before the sterilization is performed and more than 30 days before the expected date of confinement;

(ii) In cases of emergency abdominal surgery (other than cesarean section), the consent form must have been signed at least 72 hours before the sterilization was performed.

(B) The client must sign and date the consent form before it is signed and dated by the person obtaining the consent. The date of signature must meet the above criteria. The person obtaining the consent must sign the consent form anytime after the client has signed but before the sterilization is performed. If an interpreter is provided to assist the individual being sterilized, the interpreter must also sign the consent form on the same date as the client;

(C) The client must be legally competent to give informed consent. The physician performing the procedure, and the person obtaining the consent, if other than the

physician, must review with the client the detailed information appearing on the Consent to Sterilization form regarding effects and permanence of the procedure, alternative birth control methods, and explain that withdrawal of consent at any time prior to the surgery will not result in any loss of other program benefits.

(10) Involuntary Sterilization -- Clients who lack the ability to give informed consent and are 18 years of age or older:

(a) Only the Circuit Court of the county in which the client resides can determine that the client is unable to give informed consent;

(b) The Circuit Court must determine that the client requires sterilization;

(c) When the court orders sterilization, it issues a Sterilization Order. The order must be attached to the billing invoice. No waiting period or additional documentation is required.

(11) Submit the Consent to Sterilization Form (DMAP 742 A or B) along with the claim. The Consent to Sterilization form must be completed in full:

(a) Consent forms submitted to the Division without signatures and/or dates of signature by the client or the person obtaining consent are invalid;

(b) The client and the person obtaining consent may not sign or date the consent retroactively;

(c) The performing physician must sign the consent form. The date of signature must be either the date the sterilization was performed or a date following the sterilization.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

410-130-0585 – Family Planning Services

(1) Family planning services are those intended to prevent or delay pregnancy, or otherwise control family size.

(2) The Division of Medical Assistance Programs (Division) covers family planning services for clients of childbearing age (including minors who are considered to be sexually active).

(3) Family Planning services include:

(a) Annual exams;

(b) Contraceptive education and counseling to address reproductive health issues;

(c) Laboratory tests;

(d) Radiology services;

(e) Medical and surgical procedures, including tubal ligations and vasectomies;

(f) Pharmaceutical supplies and devices.

(4) Clients may seek family planning services from any provider enrolled with the Division, even if the client is enrolled in a Prepaid Health Plan (PHP). Reimbursement for family planning services is made either by the client's PHP or the Division. If the provider is:

(a) A participating provider with the client's PHP, bill the PHP;

(b) An enrolled Division provider, but is not a participating provider with the client's PHP, bill the Division and add modifier –FP to the billed code.

(5) Family planning methods include natural family planning, abstinence, intrauterine device, cervical cap, prescriptions, subdermal implants, condoms, and diaphragms.

(6) Bill all family planning services with the most appropriate ICD-9CM diagnosis code in the V25 series or V26.41-V26.49 (Contraceptive Management), the most appropriate CPT or HCPCS code and add modifier –FP.

(7) For annual family planning visits use the appropriate CPT code in the Preventative Medicine series (9938X-9939X) and add modifier FP. These codes include comprehensive contraceptive counseling.

(8) When comprehensive contraceptive counseling is the only service provided at the encounter, use a CPT code from the Preventative Medicine, Individual Counseling series (99401-99404) and add modifier -FP.

(9) Bill contraceptive supplies with the most appropriate HCPCS codes.

(10) Where there are no specific CPT or HCPCS codes, use an appropriate unlisted code and add modifier -FP. Bill supplies at acquisition cost.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065, 414.025, 414.152

410-130-0587 – Family Planning Clinic Services

(1) This rule pertains only to Family Planning Clinics.

(2) To enroll with the Division of Medical Assistance Programs (Division) as a family planning clinic, a provider must also be enrolled with the Office of Family Health as an Oregon Contraceptive Care (CCare) provider.

(3) Family planning clinics must follow all applicable CCare and the Division rules.

(4) The Division will reimburse family planning clinics an encounter rate only when the primary purpose of the visit is for family planning.

(5) Bill HCPCS code T1015 “Clinic visit/encounter, all-inclusive; family planning” for all encounters where the primary purpose of the visit is contraceptive in nature:

(a) This encounter code includes the visit and any procedure or service performed during that visit including:

(A) Annual family planning exams;

(B) Family planning counseling;

(C) Insertions and removals of implants and IUDs;

(D) Diaphragm fittings;

(E) Dispensing of contraceptive supplies and contraceptive medications;

(F) Contraceptive injections.

(b) Do not bill procedures, such as IUD insertions, diaphragm fittings or injections, with CPT or HCPCS codes;

(c) Bill only one encounter per date of service;

(d) Reimbursement for educational materials is included in T1015. Educational materials are not billable separately.

(6) Reimbursement for T1015 does not include payment for family planning (FP) supplies and medications:

(a) Bill contraceptive supplies and contraceptive medications separately using HCPCS codes. Where there are no specific HCPCS codes, use an appropriate unspecified HCPCS code:

(A) Bill spermicide code A4269 per tube;

(B) Bill contraceptive pills code S4993 per monthly packet;

(C) Bill emergency contraception with code S4993 and bill per packet.

(b) Bill all contraceptive supplies and contraceptive medications at acquisition cost;

(c) Add modifier -FP after all codes for contraceptive services, supplies and medications;

(d) Non-contraceptive medications are not billable under this program.

(7) Reimbursement for T1015 does not include payment for laboratory tests:

(a) Clinics and providers who perform lab tests in their clinics and are CLIA certified to perform those tests may bill CPT and HCPCS lab codes in addition to T1015;

(b) Add modifier -FP after lab codes to indicate that the lab was performed during an FP encounter;

(c) Labs sent to outside laboratories, such as PAP smears, can be billed only by the performing laboratory.

(8) Encounters where the primary purpose of the visit is not contraceptive in nature, use appropriate CPT codes and do not add modifier -FP.

(9) When billing providers who are not participants in a Prepaid Health Plan (PHP) for services provided to clients enrolled in a PHP, add modifier –FP to the billed code.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.152

410-130-0595 – Maternity Case Management

(1) The primary purpose of the Maternity Case Management (MCM) program is to optimize pregnancy outcomes, including reducing the incidence of low birth weight babies. MCM services are tailored to the individual client needs. These services are provided face-to-face throughout the client's pregnancy, unless specifically indicated in this rule.

(2) This program:

(a) Is available to all pregnant clients receiving Medical Assistance Program coverage;

(b) Expands perinatal services to include management of health, economic, social and nutritional factors through the end of pregnancy and a two-month postpartum period;

(c) Must be initiated during the pregnancy and before delivery;

(d) Is an additional set of services over and above medical management of pregnant clients;

(e) Allows billing of intensive nutritional counseling services.

(3) Any time there is a significant change in the health, economic, social, or nutritional factors of the client, the prenatal care provider must be notified.

(4) Only one provider at a time may provide MCM services to the client. The provider must coordinate care to ensure that duplicate claims for MCM services are not submitted to the Division.

(5) Definitions:

(a) Case Management -- An ongoing process to assist and support an individual pregnant client in accessing necessary health, social, economic, nutritional, and other services to meet the goals defined in the Client Service Plan (CSP)(defined below);

(b) Case Management Visit -- A face-to-face encounter between a Maternity Case Manager and the client that must include two or more specific training and education topics, address the CSP and provide an on-going relationship development between the client and the visiting provider.

(c) Client Service Plan (CSP) -- A written systematic, client coordinated plan of care which lists goals and actions required to meet the needs of the client as identified in

the Initial Assessment (defined below) and includes a client discharge plan/summary;

(d) High Risk Case Management -- Intensive level of services provided to a client identified and documented by the Maternity Case Manager or prenatal care provider as being high risk;

(e) High Risk Client -- A client who has a current (within the last year) documented alcohol, tobacco or other drug (ATOD) abuse history, or who is 17 or under, or has other conditions identified by the case manager anytime during the course of service delivery;

(f) Home/Environmental Assessment -- A visit to the client's primary place of residence to assess the health and safety of the client's living conditions;

(g) Initial Assessment -- Documented, systematic collection of data with planned interventions as outlined in a CSP to determine current status and identify needs and strengths in physical, psychosocial, behavioral, developmental, educational, mobility, environmental, nutritional, and emotional areas;

(h) Nutritional Counseling -- Intensive nutritional counseling for clients who have at least one of the conditions listed under Nutritional Counseling (12)(a)(A-I) in this rule;

(i) Prenatal/Perinatal care provider -- The physician, licensed physician assistant, nurse practitioner, certified nurse midwife, or licensed direct entry midwife providing prenatal or perinatal (including labor and delivery) and/or postnatal services to the client;

(j) Case Management Visit Outside the Home -- An encounter outside the client’s home between a Maternity Case Manager and the client where identical services of a Case Management Home Visit (G9012) are provided.

(6) Maternity case manager qualifications:

(a) Maternity case managers must be currently licensed as a:

(A) Physician;

(B) Physician assistant;

(C) Nurse practitioner;

(D) Certified nurse midwife;

(E) Direct entry midwife;

(F) Social worker; or

(G) Registered nurse;

(b) The maternity case manager must be a Division enrolled provider or deliver services under an appropriate Division enrolled provider. See provider qualifications in the Division's General Rule 410-1201260.

(c) All of the above must have a minimum of two years of related and relevant work experience;

(d) Other paraprofessionals may provide specific services with the exclusion of the Initial Assessment (G9001) while working under the supervision of one of the practitioners listed above in this section;

(e) The maternity case manager must sign off on all services delivered by a paraprofessional;

(f) Specific services not within the recognized scope of practice of the provider of MCM services must be referred to an appropriate discipline.

(7) Nutritional counselor qualifications -- nutritional counselors must be:

(a) A licensed dietician (LD) licensed by the Oregon Board of Examiners of Licensed Dieticians; and

(b) A registered dietician (RD) credentialed by the Commission on Dietetic Registration of the American Dietetic Association (ADA).

(8) Documentation requirements:

(a) Documentation is required for all MCM services in accordance with Division General Rule 410-120-1360; and

(b) A correctly completed Division form 2470, 2471, 2472 and 2473 or their equivalents meet minimum documentation requirements for MCM services.

(9) G9001 -- Initial Assessment must be performed by a licensed maternity case manager as defined under (6)(a)(A-G) in this rule:

(a) Services include:

(A) Client assessment as outlined in the "Definitions" section of this rule;

(B) Development of a CSP that addresses identified needs;

(C) Making and assisting with referrals as needed to:

(i) A prenatal care provider;

(ii) A dental health provider;

(D) Forwarding the Initial Assessment and the CSP to the prenatal care provider;

(E) Communicating pertinent information to the prenatal care provider and others participating in the client's medical and social care;

(b) Data sources relied upon may include:

(A) Initial Assessment;

(B) Client interviews;

(C) Available records;

(D) Contacts with collateral providers;

(E) Other professionals; and

(F) Other parties on behalf of the client;

(c) The client's record must reflect the date and to whom the Initial Assessment was sent;

(d) The Initial Assessment (G9001) is billable once per pregnancy per provider and must be performed before providing any other MCM services. Only a Home/Environmental Assessment (G9006) and a Case Management Home Visit (G9012) or Case Management Visit Outside the Home (G9011) may be performed and billed on the same day as an Initial Assessment.

(10) G9002 -- Case Management includes:

(a) Face-to-face client contacts;

(b) Implementation and monitoring of a CSP:

(A) The client's records must include a CSP and written updates to the plan;

(B) The CSP includes determining the client's strengths and needs, setting specific goals and utilizing appropriate resources in a cooperative effort between the client and the maternity case manager;

(c) Care coordination as follows:

(A) Contact with Department of Human Services (Department) case worker, if assigned;

(B) Maintain contact with prenatal care provider to ensure service delivery, share information, and assist with coordination;

(C) Contact with other community resources/agencies to address needs;

(d) Linkage to client services indicated in the CSP:

(A) Make linkages, provide information and assist the client in self-referral;

(B) Provide linkage to labor and delivery services;

(C) Provide linkage to family planning services as needed;

(e) Ongoing nutritional evaluation with basic counseling and referrals to nutritional counseling, as indicated;

(f) Utilization and documentation of the “5 A’s” brief intervention protocol for addressing tobacco use (US Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence, 2008). Routinely:

(A) Ask all clients about smoking status;

(B) Advise all smoking clients to quit;

(C) Assess for readiness to try to quit;

(D) Assist all those wanting to quit by referring them to the Quitline and/or other appropriate tobacco cessation counseling and provide motivational information for those not ready to quit;

(E) Arrange follow-up for interventions;

(g) Provide training and education on all mandatory topics - Refer to Table 130-0595-2 in this rule;

(h) Provide client advocacy as necessary to facilitate access to benefits or services;

(i) Assist client in achieving the goals in the CSP;

(j) G9002 is billable when three months or more of services were provided. Services must be initiated during the prenatal period and carried through the date of delivery;

(k) G9002 is billable once per pregnancy.

(11) G9005 -- High Risk Case Management:

(a) Enhanced level of services that are more intensive and are provided in addition to G9002;

(b) A client can be identified as high risk at any time when case management services are provided, therefore G9005 can be billed after 3 months of case management services.

(c) G9005 is billable only once per pregnancy per provider.

(d) G9002 can not be billed in addition to G9005.

(12) S9470 -- Nutritional counseling:

(a) Is available for clients who have at least one of the following conditions:

(A) Chronic disease such as diabetes or renal disease;

(B) Hematocrit (Hct) less than 34 or hemoglobin (Hb) less than 11 during the first trimester, or Hct less than 32 or Hb less than 10 during the second or third trimester;

(C) Pre-gravida weight under 100 pounds or over 200 pounds;

(D) Pregnancy weight gain outside the appropriate Women, Infants and Children (WIC) guidelines;

(E) Eating disorder;

(F) Gestational diabetes;

(G) Hyperemesis;

(H) Pregnancy induced hypertension (pre-eclampsia); or

(I) Other identified conditions;

(b) Documentation must include all of the following:

(A) Nutritional assessment;

(B) Nutritional care plan;

(C) Regular client follow-up;

(c) Can be billed in addition to other MCM services;

(d) S9470 is billable only once per pregnancy.

(13) G9006 -- Home/Environmental Assessment:

(a) Includes an assessment of the health and safety of the client's living conditions with training and education of all topics as indicated in Table 130-0595-1 in this rule;

(b) G9006 may be billed only once per pregnancy, except an additional Home/Environmental Assessments may be billed with documentation of problems which necessitate follow-up assessments or when a client moves. Documentation must be submitted with the claim to support the additional Home/Environment Assessment.

(14) G9011 -- Case Management Visit Outside the Home:

(a) A face-to-face encounter between a maternity case manager and the client in a place other than the home which meets all requirements of a Case Management Home Visit (G9012) or a telephone encounter when a face-to-face Case Management Visit is not possible or practical;

(b) G9011 is billable in lieu of a Case Management Home Visit and counted towards the total number of Case Management Home Visits (see G9012 for limitations).

(15) G9012 – Case Management Home Visit:

(a) Each Case Management Home Visit must be performed in the client’s home and must include:

(A) An evaluation and/or revision of objectives and activities addressed in the CSP: and

(B) At least two training and education topics listed in Table 1300595-2 in this rule;

(b) Four Case Management Home Visits (G9012) may be billed per pregnancy. Case Management Visits Outside the Home (G9011) are included in this limitation;

(c) Six additional Case Management Home Visits may be billed if the client is identified as high risk and services were provided for three months or longer;

(d) These additional six visits may only be billed with or after High Risk Case Management (G9005) has been billed. Case Management Visits Outside the Home (G9011) are included in this limitation.

(16)Table 130-0595-1

(17)Table 130-0595-2

Stat. Auth.: ORS 409.050 and 414.065

Stats. Implemented: ORS 414.065

Table 130-0595-1 – Environmental Assessment

Housing Characteristics

Location of home and proximity to exposures

General assessment and condition of home as shelter

Number of bedrooms and number of persons

Heating and cooling

Ventilation and windows

Locking entrance

Phone service

Running/potable water

Access to bathroom

Sanitation/sewage and garbage

General Safety

Guns/weapons: locked and unloaded

Lighting adequate for safety

Fall/Trip hazards

Temperatures of hot tubs and hot water tanks

Non-slip shower and bath surfaces

Food Safety

Food preparation facilities

Refrigeration

Cleanable surfaces

Food storage facilities

Health adequacy: safety and sanitation

Table 130-0595-1 – Environmental Assessment

Toxins/Teratogens

Pesticides

Lead exposure: peeling paint, lead pipes and lead dust

Household cleaners

Indoor Air

Tobacco smoke – second- and third-hand

Wood/Pellet stoves

Mold and mildew

Carbon monoxide risk

Chemical use: in or near home

Radon risk

Asbestos

Pollutants: air fresheners, candles, plug-ins and incense

Fire Prevention

Fire hazards: smoking, candles and flammable item storage

Electrical outlets

Emergency Planning

Smoke alarms: installed and working

Adequate exits: all locations and free of obstacles

Emergency preparedness: escape plan; emergency numbers posted; adequate food, water and supplies; alternate heating, lighting and cooking capability

Transportation

Occupations & Hobbies

Employment, such as: nail salons, painters, remodelers, home repair, radiator repair, dry cleaning, gardener, pesticide applicator, farm/orchard worker, landscape worker

Hobbies, such as: making and using fishing weights or bullets; shooting or cleaning at indoor shooting ranges

Table 130-0595-1 – Environmental Assessment

Miscellaneous

Pets: presence or care of dogs, cats, birds, reptiles (lizards & snakes) and turtles

Cleaning of cat litter box and other pet cages Administering flea or tick treatments to pets

Pests: presence or management of mice, rats, insects, bedbugs, etc.

Table 130-0595-2 MCM – Training and Education Topics

MANDATORY TOPICS

Alcohol, tobacco and other drug exposure Maternal oral health

Breastfeeding promotion

Perinatal mood disorders

Prematurity and pre-term birth risks

Maternal/Fetal HIV (Human Immunodeficiency Virus) and Hepatitis B transmission
Nutrition, healthy weight and physical activity Intimate Partner Violence (IPV)

NON-MANDATORY TOPICS

Pregnancy and Childbirth	Common discomforts and interventions Labor and birth process Coping strategies Relationship changes Stress reduction Pregnancy danger signs and symptoms Fetal growth and development Safety in automobiles: proper use of seat belts and infant car seats Other emergencies
Health Status	Medications Digestive tract changes Food availability Food selection and preparation Mercury consumption from eating fish Other existing health conditions during pregnancy

Environmental Health	Housing Safety and sanitation Toxins/Teratogens Occupational exposures Drinking water Non-fluoridated water community Home cleaning supplies Tobacco smoke exposure Asthma triggers Lead exposure and screening
Parenting	Infant care Early childhood caries prevention Nutrition, feeding and infant growth Infant sleep patterns and location SIDS (Sudden Infant Death Syndrome) and “Back to Sleep” Infant developmental milestones Immunizations and well child care Infant/Parent interaction Bonding and attachment Infant communication patterns and cues Parental frustration and sleep deprivation Child nurturing, protection and safety
Other Topics	Individual and family emergency preparedness Family planning Sexually transmitted diseases Inter-conception and pre-conception health

	Community resources Obtaining accurate health information

410-130-0610 – Telemedicine

(1) For the purposes of this rule, telemedicine is defined as the use of medical information, exchanged from one site to another, via telephonic or electronic communications, to improve a patient's health status.

(2) Provider Requirements:

(a) The referring and evaluating practitioner must be licensed to practice medicine within the state of Oregon or within the contiguous area of Oregon and must be enrolled as a Division of Medical Assistance Programs (Division) provider.

(b) Providers billing for covered telemedicine services are responsible for the following:

(A) Complying with HIPAA and/or Oregon Health Authority (Authority) (OHA) Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records requirements. Examples of applicable OHA rules are Confidentiality and Privacy and Financial, Clinical and other record Rules include: OAR 943-120-0170, 410-120-1360, and 410-120-1380, and OAR 943 Division 14. Examples of federal and state privacy and security laws that may apply include HIPAA, if applicable and 42 CFR Part 2, if applicable and ORS 646A.600 to 646A.628 (Oregon Consumer Identity Theft Protection Act);

(B) Obtaining and maintaining technology used in the telemedicine communication that is compliant with privacy and security standards in HIPAA and/or Department Privacy and Confidentiality Rules described in subsection (A).

(C) Ensuring policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records (whether oral or recorded in any form or medium) to unauthorized persons.

(D) Complying with the relevant Health Service Commission (HSC) practice guideline for telephone and email consultation.

(E) Maintaining clinical and financial documentation related to telemedicine services as required in OAR 410-120-1360.

(3) Coverage for telemedicine services:

(a) The telemedicine definition encompasses different types of programs, services and delivery mechanisms for medically appropriate covered services within the patient's benefit package.

(b) Patient consultations using telephone and online or electronic mail (E-mail) are covered when billed services comply with the practice guidelines set forth by the Health Service Commission (HSC) and the applicable HSC-approved CPT code requirements, delivered consistent with the HSC practice guideline.

(c) Patient consultations using videoconferencing, a synchronous (live two-way interactive) video transmission resulting in real time communication between a medical practitioner located in a distant site and the client being evaluated and located in an originating site, is covered when billed services comply with the Billing requirements stated in (5).

(d) Telephonic codes may be used in lieu of videoconferencing codes, if videoconferencing equipment is not available.

(4) Telephone and E-mail billing requirements: Use the E/M code authorized in the HSC practice guideline.

(5) Videoconferencing billing requirements:

(a) Only the transmission site (where the patient is located) may bill for the transmission:

(A) Bill the transmission with Q3014;

(B) The referring practitioner may bill an E/M code only if a separately identifiable visit is performed. The visit must meet all of the criteria of the E/M code billed.

(C) The referring provider is not required to be present with the client at the originating site.

(b) The evaluating practitioner at the distant site may bill for the evaluation, but not for the transmission (Q3014):

(A) Bill the most appropriate E/M code for the evaluation;

(B) Add modifier GT to the E/M code to designate that the evaluation was made by a synchronous (live and interactive) transmission.

(6) Other forms of telecommunications, such as telephone calls, images transmitted via facsimile machines and electronic mail are services not covered:

(a) When those forms are not being used in lieu of videoconferencing, due to limited videoconferencing equipment access, or

(b) When those forms and specific services are not specifically allowed per the Health Service Prioritized List and Practice Guideline.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

410-130-0670 – Death With Dignity

(1) All Death with Dignity services must be billed directly to the Division of Medical Assistance Programs (Division), even if the client is in a managed care plan.

(2) Death with Dignity is a covered service, incorporated in the "comfort care" condition/treatment line on the Health Services Commission's Prioritized List of Health Services.

(3) The following physician visits and medical encounters are billable when performed by a licensed physician or psychologist:

(a) The medical confirmation of the terminal condition;

(b) The two visits in which the client makes the oral request;

(c) The visit in which the written request is made;

(d) The visit in which the prescription is written;

(e) Counseling consultation(s); and

(f) Medication and dispensing.

(4) More than one of the services listed in sections (3)(a) through (3)(f) may be provided during the same visit. Additional visits for discussion or counseling are also covered for payment.

(5) Billing:

(a) All claims for Death with Dignity services must be made on a paper CMS-1500 billing form;

(b) Do not submit a claim for Death with Dignity services electronically or on an 837P;

(c) Claims must be submitted using appropriate CPT or HCPCS codes;

(d) The Division unique diagnosis code PAD-00 must be entered in Field 21 of the CMS-1500 billing form. Do not list any additional diagnosis codes in this field;

(e) Claims must be submitted only on paper to: DMAP, PO Box 992, Salem, Oregon 97308-0992;

(f) Prescriptions must be billed only with the Division unique code 8888-PAID-00. This code must be entered in Field 24D of the CMS1500. In addition, the actual NDC

number of the drug dispensed and the dosage must be listed below the prescription code;

(g) The Division may be billed for prescription services only when the pharmacy has been properly notified by the physician in accordance with OAR 847-015-0035. This OAR requires the physician to have the client's written consent to contact and inform the pharmacist of the purpose of the prescription.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-130-0680 – Laboratory and Radiology

(1) The following tables list the medical and surgical services that:

(a) Require prior authorization (PA) – OAR 410-130-0200 Table 130-02001 (PET scans require PA and are included in the table), and;

(b) Are not covered/bundled – OAR 410-130-0220 Table 130-0220-1.

(2) Newborn screening (NBS) kits and collection and handling for newborn screening (NBS) tests performed by the Oregon State Public Health Laboratory (OSPHL) are considered bundled into the delivery fee and, therefore, must not be billed separately. Replacement of lost NBS kits may be billed with code S3620 with modifier –TC. The loss must be documented in the client's medical record. NBS confirmation tests performed by reference laboratories at the request of the OSPHL will be reimbursed only to the OSPHL.

(3) The Division of Medical Assistance Programs (Division) covers lab tests performed in relation to a transplant only if the transplant is covered and if the transplant has been authorized. See the Division Transplant Services administrative rules (chapter 410, division 124).

(4) All lab tests must be specifically ordered by, or at the direction of a licensed medical practitioner within the scope of their license.

(5) If a lab sends a specimen to a reference lab for additional testing, the reference lab may not bill for the same tests performed by the referring lab.

(6) When billing for lab tests, use the date that the specimen was collected as the date of service (DOS) even if the tests were not performed on that date.

(7) Reimbursement for drawing/collecting or handling samples:

(a) The Division will reimburse providers once per day regardless of the frequency performed for drawing/collecting the following samples:

(A) Blood – by venipuncture or capillary puncture, and;

(B) Urine – only by catheterization.

(b) The Division will not reimburse for the collection and/or handling of other specimens, such as PAP or other smears, voided urine samples, or stool specimens. Reimbursement is bundled in the reimbursement for the exam and/or lab procedures and is not payable in addition to the laboratory test.

(8) Pass-along charges from the performing laboratory to another laboratory, medical practitioner, or specialized clinic are not covered for payment and are not to be billed to the Division.

(9) Only the provider who performs the test(s) may bill the Division.

(10) Clinical Laboratory Improvement Amendments (CLIA) Certification:

(a) The Division will only reimburse laboratory services to providers who are CLIA certified by the Centers for Medicare and Medicaid Services (CMS);

(b) CLIA requires all entities that perform even one test, including waived tests on... "materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings" to meet certain Federal requirements. If an entity performs tests for these purposes, it is considered under CLIA to be a laboratory;

(c) Providers must notify the Division of the assigned ten-digit CLIA number;

(d) Payment is limited to the level of testing authorized by the CLIA certificate at the time the test is performed.

(11) Organ Panels:

(a) The Division will only reimburse panels as defined by the CPT codes for the year the laboratory service was provided. Tests within a panel may not be billed individually even when ordered separately. The same panel may be billed only once per day per client;

(b) The Division will pay at the panel maximum allowable rate if two or more tests within the panel are billed separately and the total reimbursement rate of the combined codes exceeds the panel rate, even if all the tests listed in the panel are not ordered or performed.

(12) Radiology:

(a) Provision of diagnostic and therapeutic radionuclide(s), HCPCS A9500A9699, are payable only when given in conjunction with radiation oncology and nuclear medicine codes 77401-79999;

(b) HCPCS codes R0070 through R0076 are covered.

(13) Reimbursement of contrast and diagnostic-imaging agents is bundled in the radiology procedure except for low osmolar contrast materials (LOCM).

(14) Supply of LOCM may be billed in addition to the radiology procedure only when the following criteria are met:

(a) Prior adverse reaction to contrast material, with the exception of a sensation of heat, flushing or a single episode of nausea or vomiting;

(b) History of asthma or significant allergies;

(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction or pulmonary hypertension;

(d) Decrease in renal function;

(e) Diabetes;

(f) Dysproteinemia;

(g) Severe dehydration;

(h) Altered blood brain barrier (i.e., brain tumor, subarachnoid hemorrhage);

(i) Sickle cell disease, or;

(j) Generalized severe debilitation.

(15) X-ray and EKG interpretations in the emergency room:

(a) The Division reimburses only for one interpretation of an emergency room patient's x-ray or EKG. The interpretation and report must have directly contributed to the diagnosis and treatment of the patient;

(b) The Division considers a second interpretation of an x-ray or EKG to be for quality control purposes only and will not be reimbursed;

(c) Payment may be made for a second interpretation only under unusual circumstances, such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

410-130-0700 – HCPCS Supplies and DME

(1) Use appropriate HCPCS codes to bill all supplies and DME.

(2) For items that do not have specific HCPCS codes:

(a) Use unlisted HCPCS code;

(b) Bill at acquisition cost, purchase price plus postage.

(3) CPT code 99070 is no longer billable for supplies and materials. Use HCPCS codes.

(4) Use S3620 with modifier TC for lost newborn screening (NBS) kits.

(5) The Division of Medical Assistance Programs (Division) bundles reimbursement for office surgical suites and office equipment in the reimbursement of surgical procedures.

(6) Contraceptive Supplies--Refer to OAR 410-130-0585.

(7) A4000-A9999:

(a) All “A” codes listed in Table 130-0700-1 are covered under this program;

(b) All “A” codes not listed in Table 130-0700-1 must be referred to a Durable Medical Equipment (DME) provider;

(c) Do not use A4570, A4580 and A4590 for splint and cast materials. Use codes Q4001-Q4051;

(d) A9150-A9999 (administrative, investigational, and miscellaneous) are not covered, except for A9500-A9699. Refer to OAR 410-130-0680.

(8) B4000-B9999:

(a) HCPCS codes B4034-B4036 and B4150-B9999 are not covered for medical-surgical providers;

(b) Refer these services to home enteral/parenteral providers.

(9) C1000-C9999 are not covered.

(10) E0100-E1799: DMAP covers only the following DME HCPCS codes for medical-surgical providers when provided in an office setting:

(a) E0100-E0116;

(b) E0602;

(c) E0191;

(d) E1399;

(e) Refer all other items with "E" series HCPCS codes to DME providers.

(11) J0000-J9999 HCPCS codes--Refer to OAR 410-130-0180 for coverage of drugs.

(12) K0000-K9999 HCPCS codes--Refer all items with "K" series to DME providers.

(13) L0000-L9999:

(a) Refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies program Administrative rules for coverage criteria for orthotics and prosthetics;

(b) Refer to Table 130-0220-1 for a list of “L” codes that are not covered;

(c) Reimbursement for orthotics is a global package, which includes:

(A) Measurements;

(B) Moldings;

(C) Orthotic items;

(D) Adjustments;

(E) Fittings;

(F) Casting and impression materials.

(d) Evaluation and Management codes are covered only for the diagnostic visit where the medical appropriateness for the orthotic is determined and for follow-up visits unrelated to the fitting of the orthotic.

(14) Refer to Table 130-0700-1 for supplies and DME covered in the office setting.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

Table 130-0700-1 – Supplies and DME Covered in Office Setting

A4220
A4260-A4263
A4266-A4269
A4300
A4305-A4320
A4322-A4328
A4330-A4331
A4333-A4346
A4348-A4362
A4367
A4369
A4371-A4373
A4375-A4385
A4387-A4399
A4404-A4421
A4462-A4465
A4550
A4561-A4562
A4565
A4649
A5051-A5112
A5500-A5507
A5509-A5511
A6010-A6011
A6021-A6224
A6231-A6248
A6251-A6259
A6261-A6262
A6266-A6404
A6421-A6438
B4081-B4083
B4086
E0100-E0116
E0191
E0602
E1399