

Secretary of State
NOTICE OF PROPOSED RULEMAKING*
A Statement of Need and Fiscal Impact accompanies this form

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8-12-15 5:55 PM
ARCHIVES DIVISION
SECRETARY OF STATE

Oregon Health Authority, Division of Medical Assistance Programs

Agency and Division

410

Administrative Rules Chapter Number

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RULE CAPTION

Update International Classification of Diseases Coding from ICD-9 to ICD-10

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

Secure approval of rule numbers with the Administrative Rules Unit prior to filing

ADOPT:

AMEND:

OAR 410-120-1280, 410-121-0185, 410-122-0020, 410-122-0205, 410-122-0330, 410-122-0400, 410-122-0662, 410-123-1260, 410-123-1620, 410-124-0000, 410-124-0020, 410-124-0060, 410-124-0063, 410-124-0065, 410-124-0070, 410-124-0080, 410-124-0090, 410-124-0100, 410-124-0105, 410-124-0120, 410-125-0045, 410-125-0141, 410-125-1080, 410-125-2020, 410-127-0040, 410-129-0060, 410-130-0160, 410-130-0190, 410-130-0562, 410-130-0585, 410-131-0080, 410-133-0040, 410-140-0040, 410-140-0120, 410-140-0260, 410-141-0480, 410-146-0040, 410-146-0085, 410-147-0040, 410-147-0120, 410-147-0500, 410-148-0020

REPEAL:

RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

AMEND AND RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

Statutory Authority:

ORS 413.042, 414.065, 414.707

Other Authority:

Statutes Implemented:

ORS 414.025, 414.065, 414.152, 414.707 & 688.135

RULE SUMMARY

Currently ICD-9 is the International Classification of Diseases that is used by providers to input diagnosis codes on claims. Effective October 1, 2015 the coding will change to ICD-10. The Authority needs to amend and update these rules to reflect the change to ICD-10. The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA). The change to ICD-10 does not affect CPT coding for outpatient procedures and physician services.

A public rulemaking hearing may be requested in writing by 10 or more people, or by an association with 10 or more members, within 21 days following the publication of the Notice of Proposed Rulemaking in the Oregon Bulletin or 28 days from the date Notice was sent to people on the agency mailing list, whichever is later. If sufficient hearing requests are received, the notice of the date and time of the rulemaking hearing must be published in the Oregon Bulletin at least 14 days before the hearing.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

<u>09-17-2015 5:00 p.m.</u>	<u>Sandy Cafourek</u>	<u>dmap.rules@state.or.us</u>
Last Day (m/d/yyyy) and Time for public comment	Rules Coordinator Name	Email Address

*The Oregon Bulletin is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation.

Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT
A Notice of Proposed Rulemaking accompanies this form.

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Oregon Health Authority, Division of Medical Assistance Programs
Agency and Division

410

Administrative Rules Chapter Number

Update International Classification of Diseases Coding from ICD-9 to ICD-10

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of:

The Amendment of OAR 410-120-1280, 410-121-0185, 410-122-0020, 410-122-0205, 410-122-0330, 410-122-0400, 410-122-0662, 410-123-1260, 410-123-1620, 410-124-0000, 410-124-0020, 410-124-0060, 410-124-0063, 410-124-0065, 410-124-0070, 410-124-0080, 410-124-0090, 410-124-0100, 410-124-0105, 410-124-0120, 410-125-0045, 410-125-0141, 410-125-1080, 410-125-2020, 410-127-0040, 410-129-0060, 410-130-0160, 410-130-0190, 410-130-0562, 410-130-0585, 410-131-0080, 410-133-0040, 410-140-0040, 410-140-0120, 410-140-0260, 410-141-0480, 410-146-0040, 410-146-0085, 410-147-0040, 410-147-0120, 410-147-0500, 410-148-0020

Statutory Authority:

ORS 413.042, 414.065, 414.707

Other Authority:

Statutes Implemented:

ORS 414.025, 414.065, 414.152, 414.707 & 688.135

Need for the Rule(s):

Currently ICD-9 is the International Classification of Diseases that is used by providers to input diagnosis codes on claims. Effective October 1, 2015 the coding will change to ICD-10. The Authority needs to amend and update these rules to reflect the change to ICD-10.

Documents Relied Upon, and where they are available:

<https://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10>

Fiscal and Economic Impact:

None

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

Amending these rules will have no fiscal impact on the Authority, other state agencies, units of local government, or the public.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small business and types of businesses and industries with small businesses subject to the rule:

The Authority estimates that there are 83,512 enrolled providers. The Authority does not track the size of provider offices and has no data on how many have less than 50 employees. There may be a fiscal impact to providers in changing the diagnostic coding; however, the Authority does not have information on the number of providers or the types of changes each provider will need to make. The Authority estimates that the fiscal impact will be minimal.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

Providers may be impacted by these rule amendments, since they may need to update office forms, provide staff training. The Authority does not know how many providers will need to make changes that may cause a fiscal impact.

c. Equipment, supplies, labor and increased administration required for compliance:

N/A

How were small businesses involved in the development of this rule?

Small businesses were not involved because the changes to these rules are being made due to a transition from ICD-9 to ICD-10 by CMS and the American Medical Association.

Administrative Rule Advisory Committee consulted?:No

If not, why?:

Amending rules based on CMS action.

<u>09-17-2015 5:00 p.m.</u>	<u>Sandy Cafourek</u>	<u>dmap.rules@state.or.us</u>
Last Day (m/d/yyyy) and Time for public comment	Printed Name	Email Address

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

ARC 925-2007

DIVISION 120 GENERAL RULES

410-120-1280

Billing

(1) A provider enrolled with the Authority or providing services to a client in a CCO or PHP under the Oregon Health Plan (OHP) may not seek payment, from the client for any services covered by Medicaid fee-for-service or through contracted health care plans:

(a) A client may not be billed for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Division;

(b) A client may not be billed for services or treatments that have been denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.).

(2) For Medicaid covered services the provider may not bill the Division more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Division program rules.

(3) Providers shall only bill a client or a financially responsible relative or representative of that client in the following situations:

(a) For any applicable coinsurance, copayments and deductibles expressly authorized in OAR chapter 410, divisions 120 and 141, or any other Division program rules;

(b) The client did not inform the provider of their OHP coverage, enrollment in a PHP or CCO, or third party insurance coverage at the time of or after a service was provided, therefore, the provider could not bill the appropriate payer for reasons including, but not limited to, the lack of prior authorization, or the time limit to submit the claim for payment has passed. The provider must verify eligibility, pursuant to OAR 410-120-1140, and document attempts to obtain coverage information prior to billing the client;

(c) The client became eligible for benefits retroactively but did not meet all of the other criteria required to receive the service);

(d) A third party payer made payments directly to the client for services provided;

(e) The client has the limited Citizen Alien Waived Emergency Medical benefit package. CAWEM clients have the benefit package identifier of CWM. Clients receiving CAWEM benefits may be billed for services that are not part of the CAWEM benefits. (See OAR 410-120-1210 for coverage.) The provider must document that the client was informed in advance that the service or item would not be covered by the Division. A DMAP 3165 is not required for these services;

(f) The client has requested a continuation of benefits during the contested case hearing process and the final decision was not in favor of the client. The client shall pay for any charges incurred for the denied service, on or after the effective date on the Notice of Action or Notice of Appeal Resolution. The provider must complete the DMAP 3165 pursuant to section (3)(h) of this rule before providing these services;

(g) In exceptional circumstances, a client may decide to privately pay for a covered service. In this situation, the provider may bill the client if the provider informs the client in advance of all of the following:

(A) The requested service is a covered service, and the appropriate payer (the Division, PHP, CCO or third party payer) would pay the provider in full for the covered service; and

(B) The estimated cost of the covered service, including all related charges, the amount that the appropriate payer would pay for the service, and that the provider cannot bill the client for an amount greater than the amount the appropriate payer would pay; and

(C) That the client knowingly and voluntarily agrees to pay for the covered service;

(D) The provider documents in writing, signed by the client or the client's representative, indicating that the provider gave the client the information described in section (3)(g)(A-C); and that the client had an opportunity to ask questions, obtain additional information and consult with the client's caseworker or client representative; and the client agreed to privately pay for the service by signing an agreement incorporating all of the information described above. The provider must give a copy of the signed agreement to the client. A provider may not submit a claim for payment for covered services to the Division or to the client's PHP, CCO or third party payer that is subject to the agreement.

(h) A provider may bill a client for services that are not covered by the Division, PHP, or CCO (see definition of non-covered services). Before providing the non-covered service, the client must sign the provider-completed Agreement to Pay (DMAP 3165), or a facsimile containing all of the information and elements of the DMAP 3165 as shown in Table 3165 of this rule. The completed DMAP 3165, or facsimile, is valid only if the estimated fee does not change and the service is scheduled within 30 days of the client's signature. Providers must make a copy of the completed DMAP 3165, or facsimile, available to the Division, PHP or CCO upon request.

(4) Code Set requirements:

(a) Federal Code Set requirements (45 CFR 162) apply to all Medicaid Code Set requirements, including the use of diagnostic or procedure codes for prior authorization, claims submissions and payments. Code Set has the meaning set forth in 45 CFR 162.103, and it includes the codes and the descriptors of the codes. Federal Code Set requirements are mandatory, and the Division lacks any authority to delay or alter their application or effective dates as established by the U.S. Department of Health and Human Services;

(b) The Division shall adhere to the Code Set requirements in 45 CFR 162.1000–162.1011;

(c) Periodically, the Division shall update its provider rules and tables to conform to national codes. In the event of an alleged variation between a Division-listed code and a national code, the Division shall apply the national code in effect on the date of request or date of service;

(d) Only codes with limitations or requiring prior authorization are noted in rules. National Code Set issuance alone should not be construed as coverage or a covered service by the Division;

(e) The Division adopts by reference the National Code Set revisions, deletions, and additions issued and published by the American Medical Association (Current Procedural Terminology — CPT) and on the CMS website (Healthcare Common Procedural Coding System — HCPCS). This code adoption should not be construed as coverage or as a covered service by the Division.

(5) Claims:

- (a) Upon submission of a claim to the Division for payment, the provider agrees that it has complied with all Division program rules. Submission of a claim, however, does not relieve the provider from the requirement of a signed provider agreement;
- (b) A provider enrolled with the Division must bill using the Authority assigned provider number, or the National Provider Identification (NPI) number if the NPI is available, pursuant to OAR 410-120-1260;
- (c) The provider may not bill the Division more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Division program rules;
- (d) Claims must be submitted on the appropriate form as described in the individual Division program rules or electronically in a manner authorized in OAR chapter 943, division 120;
- (e) Claims must be for services provided within the provider's licensure or certification;
- (f) Unless otherwise specified, claims must be submitted after:
 - (A) Delivery of service; or
 - (B) Dispensing, shipment or mailing of the item.
- (g) The provider must submit true and accurate information when billing the Division. Use of a billing provider does not abrogate the performing provider's responsibility for the truth and accuracy of submitted information;
- (h) A claim is considered a valid claim only if all required data is entered on or attached to the claim form. See the appropriate provider rules and supplemental information for specific instructions and requirements;
- (i) A provider or its contracted agency, including billing providers, may not submit or cause to be submitted:
 - (A) Any false claim for payment;
 - (B) Any claim altered in such a way as to result in a payment for a service that has already been paid;
 - (C) Any claim upon which payment has been made or is expected to be made by another source unless the amount paid or to be paid by the other party is clearly entered on the claim form;
 - (D) Any claim for furnishing specific care, items, or services that has not been provided.
- (j) The provider is required to submit an Individual Adjustment Request or to refund the amount of the overpayment on any claim where the provider identifies an overpayment made by the Division;
- (k) A provider who, after having been previously warned in writing by the Division or the Department of Justice about improper billing practices, is found to have continued improper billing practices and has had an opportunity for a contested case hearing shall be liable to the Division for up to triple the amount of the Division established overpayment received as a result of the violation.

(6) Diagnosis code requirement:

(a) A primary diagnosis code is required on all claims, using the HIPAA nationally required diagnosis Code Set, unless specifically excluded in individual Division program rules;

(b) All diagnosis codes are required to the highest degree of specificity;

(c) Hospitals must bill using the 5th digit in accordance with methodology used in the Medicare Diagnosis Related Groups.

(7) Procedure code requirement:

(a) For claims requiring a procedure code the provider must bill as instructed in the appropriate Division program rules and must use the appropriate HIPAA procedure Code Set such as CPT, HCPCS, ICD-910-CM, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided;

(b) For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the client's condition and the services provided. Providers must use the ICD-910-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual Division program rules. Hospitals must follow national coding guidelines;

(c) When there is no appropriate descriptive procedure code to bill the Division, the provider must use the code for "unlisted services." Instructions on the specific use of unlisted services are contained in the individual provider rules. A complete and accurate description of the specific care, item, or service must be documented on the claim;

(d) Where there is one CPT, CDT, or HCPCS code that according to CPT, CDT, and HCPCS coding guidelines or standards describes an array of services, the provider must bill the Division using that code rather than itemizing the services under multiple codes. Providers may not "unbundle" services in order to increase the payment.

(8) Third party Liability (TPL):

(a) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Division shall be the payer of last resort;

(b) Providers must make reasonable efforts to obtain payment first from other resources. For the purposes of this rule "reasonable efforts" include determining the existence of insurance or other resources on each date of service by:

(A) Using an insurance database such as Electronic Verification System (EVS) available to the provider;

(B) Using the Automated Voice Response (AVR) or secure provider web portal on each date of service and at the time of billing.

(c) Except as noted in section (8)(d)(A through E) below, when third party coverage is known to the provider prior to billing the Division the provider must:

(A) Bill the TPL; and

(B) Except for pharmacy claims billed through the Division's point-of-sale system, the provider must wait 30 days from submission date of a clean claim and have not received payment from the third party; and

(C) Comply with the insurer's billing and authorization requirements; and

(D) Appeal a denied claim when the service is payable in whole or in part by an insurer.

(d) In accordance with federal regulations the provider must bill the TPL prior to billing the Division, except under the following circumstances:

(A) The covered health service is provided by an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID);

(B) The covered health service is provided by institutional services for the mentally and emotionally disturbed;

(C) The covered health services are prenatal and preventive pediatric services;

(D) Services are covered by a third party insurer through an absent parent where the medical coverage is administratively or court ordered;

(E) When another party may be liable for an injury or illness (see definition of Liability Insurance), the provider may bill the insurer, the liable party, place a lien against a settlement, or bill the Division. The provider may not both place a lien against a settlement and bill the Division. The provider may withdraw the lien and bill the Division within 12 months of the date of service. If the provider bills the Division, the provider must accept payment made by the Division as payment in full.

(e) The provider may not return the payment made by the Division in order to accept payment from a liability settlement or liability insurer or place a lien against that settlement:

(A) In the circumstances outlined in section (8)(d)(A) through (E) above, the provider may choose to bill the primary insurance prior to billing the Division. Otherwise, the Division shall process the claim and, if applicable, pay the Division's allowable rate for these services and seek reimbursement from the liable third party insurance plan;

(B) In making the decision to bill the Division the provider should be cognizant of the possibility that the third party payer may reimburse the service at a higher rate than the Division, and that, once the Division makes payment no additional billing to the third party is permitted by the provider.

(f) The provider may bill the Division directly for services that are never covered by Medicare or another insurer on the appropriate form identified in the relevant provider rules. Documentation must be on file in the provider's records indicating this is a non-covered service for purposes of Third Party Resources. See the individual provider rules for further information on services that must be billed to Medicare first;

(g) Providers shall submit an Individual Adjustment Request showing the amount of the third party payment or to refund the amount received from another source within 30 days of the date the payment is received. Failure to submit the Individual Adjustment Request within 30 days of receipt of the third party payment or to refund the appropriate amount within this time frame is considered concealment of material facts and grounds for recovery and sanction:

(A) When a provider receives a payment from any source prior to the submission of a claim to the Division, the amount of the payment must be shown as a credit on the claim in the appropriate field;

(B) Any provider who accepts third party payment for furnishing a service or item to a Division client after having billed the Division shall:

(i) Submit an Individual Adjustment Request indicating the amount of the third party payment. Follow instructions in the individual Division program rules and supplemental billing; or

(ii) When the provider has already accepted payment from the Division for the service or item, the provider shall make direct payment of the amount of the third party payment to the Division. The check to repay the Division shall include the reason the payment is being made 333and either:

(I) An Individual Adjustment Request that identifies the original claim, name and number of the client, date of service and items or services for which the repayment is made; or

(II) A copy of the Remittance Advice showing the original Division payment.

(C) Any provider who accepts payment from a client, or client's representative and is subsequently paid for the service by the Division shall reimburse the client or their representative the full amount of their payment.

(h) The Division may make a claim against any third party payer after making payment to the provider of service. The Division may pursue alternate resources following payment if it deems this a more efficient approach. Pursuing alternate resources includes, but is not limited to, requesting the provider to bill the third party and to refund the Division in accordance with this rule;

(i) For services provided to a Medicare and Medicaid dual eligible client, the Division may request the provider to submit a claim for Medicare payment, and the provider must honor that request. Under federal regulation, a provider may not charge a beneficiary (or the state as the beneficiary's subrogee) for services for which a provider failed to file a timely claim (42 CFR 424) with Medicare despite being requested to do so;

(j) If Medicare is the primary payer and Medicare denies payment, Medicare appeals must be timely pursued, and Medicare denial must be obtained prior to submitting the claim for payment to the Division. Medicare denial on the basis of failure to submit a timely appeal may result in the Division reducing from the amount of the claim any amount the Division determines could have been paid by Medicare.

(9) Full use of alternate resources:

(a) The Division shall generally make payment only when other resources are not available for the client's medical needs. Full use must be made of reasonable alternate resources in the local community;

(b) Except as provided in subsection (10) of this rule, alternate resources may be available:

(A) Under a federal or state worker's compensation law or plan;

(B) For items or services furnished by reason of membership in a prepayment plan;

(C) For items or services provided or paid for directly or indirectly by a health insurance plan or as health benefits of a governmental entity such as:

(i) Armed Forces Retirees and Dependents Act (CHAMPVA);

(ii) Armed Forces Active Duty and Dependents Military Medical Benefits Act (CHAMPUS); or

(iii) Medicare Parts A and B.

(D) To residents of another state under that state's Title XIX or state funded medical assistance programs; or

(E) Through other reasonably available resources.

(10) Exceptions:

(a) Indian Health Services or Tribal Health Facilities. Pursuant to 42 CFR 136.61 subpart G and the Memorandum of Agreement in OAR 310-146-0000, Indian Health Services facilities and tribal facilities operating under Public Law 93, Section 638 agreement are payers of last resort and are not considered an alternate resource or TPL;

(b) Veterans Administration. Veterans who are also eligible for Medicaid benefits are encouraged to utilize Veterans' Administration facilities whenever possible. Veterans' benefits are prioritized for service related conditions and as such are not considered an alternate or TPL.

(11) Table 120-1280 – TPR codes.

(12) Table – OHP Client Agreement to Pay for Health Services, DMAP 3165.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

**DIVISION 121
PHARMACEUTICAL SERVICES**

410-121-0185

Pharmacy Based Immunization Delivery

(1) When administering immunizations for adults (ages 19+) the pharmacy can bill either:

(a) Through Point-of-Sale (POS) using the appropriate National Drug Code (NDC) for the serum and the administration fee shall automatically be applied equivalent to Current Procedural Terminology (CPT) codes 90470-90474 ; or

(b) Bill on a CMS-1500 or a DMAP 505 claim form using the appropriate immunization CPT code for the serum; or

(c) Bill through the Provider Web Portal.

(2) If using a CMS-1500, you must also include:

(a) An ICD-910 diagnosis in field 21, and;

(b) The diagnosis code must be shown to the highest degree of specificity, and;

(c) Use the appropriate CPT code for the serum, code ranges 90476-90749; and

(d) Use the appropriate CPT code for the administration, code ranges 90470-90474.

(3) Pursuant to ORS 689.205 and the Board of Pharmacy administrative rules 855-019-0270 through 855-019-0290; pharmacists may prescribe and administer vaccines to children who are from the age of 11 through 18 years of age only if the pharmacy is enrolled in the Vaccines for Children (VFC) Program. The Division will not reimburse providers the cost of privately purchased vaccination.

(4) If the pharmacy is enrolled in the VFC Program, then only the administration fee shall be reimbursed by the Division and must be billed on a CMS-1500, DMAP 505 claim form, or the Provider Web Portal. For detailed information on billing for the VFC Program, refer to Medical Surgical Services OAR 410-130-0255.

Stat. Auth.: ORS 413.042, & 414.065

Stats. Implemented: ORS 414.065

DIVISION 122
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES
(DMEPOS)

410-122-0020

Orders

(1) The purchase, rental or modifications of durable medical equipment, and the purchase of supplies must have an order prior to dispensing items to a client.

(2) For any durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), a provider must have a written order signed and dated by the prescribing practitioner prior to submitting a claim to the Division of Medical Assistance Programs (Division).

(3) A provider may dispense some items based on a verbal order from the prescribing practitioner, except those items requiring a written order prior to delivery (see below) or as specified in a particular rule:

(a) A provider must maintain documentation of the verbal order and this documentation must be available to the Division upon request;

(b) The verbal order must include all the following elements:

(A) Client's name; and,

(B) Name of the practitioner; and,

(C) Description of the item; and,

(D) Start date of the order; and,

(E) Primary ICD-~~9~~10 diagnosis code for the equipment/supplies requested.

(c) For items that are dispensed based on a verbal order, the provider must obtain a written order that meets the requirements outlined below for written orders.

(4) For an item requiring a written order prior to delivery, Medicare criteria must be met.

(5) When specified in rule, a nurse practitioner may provide the dispensing order and sign the detailed written order only when the following are met:

(a) They are treating the client for the condition for which the item is needed; and

(b) They are practicing independently of a physician.

(6) The DMEPOS provider must have on file a written order, information from the prescribing practitioner concerning the client's diagnosis and medical condition, and any additional information required in a specific rule.

(7) The Division accepts any of the following forms of orders and Certificates of Medical Necessity (CMN): a photocopy, facsimile image, electronically maintained or original “pen and ink” document:

(a) An electronically maintained document is one which has been created, modified, and stored via electronic means such as commercially available software packages and servers;

(b) It is the provider’s responsibility to ensure the authenticity/validity of a facsimile image, electronically maintained or photocopied order;

(c) A provider must also ensure the security and integrity of all electronically maintained orders and/or certificates of medical necessity;

(d) The written order may serve as the order to dispense the item if the written order is obtained before the item is dispensed.

(8) A written order must be legible and contain the following elements:

(a) Client’s name; and,

(b) Detailed description of the item that can either be a narrative description (e.g., lightweight wheelchair base) or a brand name/model number including medically appropriate options or additional features; and,

(c) The detailed description of the item may be completed by someone other than the practitioner. However, the prescribing practitioner must review the detailed description and personally indicate agreement by his signature and the date that the order is signed;

(A) The Division requires practitioners to sign for services they order;

(B) This signature must be handwritten, or electronic, and it must be in the client’s medical record;

(C) The ordering practitioner is responsible for the authenticity of the signature;

(d) Primary ICD-910 diagnosis code for the equipment/supplies requested.

(9) Use of signature stamps is prohibited on any medical record.

(10) When a DMEPOS provider submits a Centers for Medicare & Medicaid Services (CMS) CMN to the Division as documentation, the following is required:

(a) The corresponding instructions for completing the specific CMN form must be followed; and

(b) Section B on the CMN cannot be completed by the DMEPOS provider;.

(11) A provider is responsible to obtain as much documentation from the client’s medical record as necessary for assurance that the Division coverage criteria for an item(s) is met.

(12) Certain items require one or more of the following additional elements in the written order:

(a) For accessories or supplies that will be provided on a periodic basis:

(A) Quantity used;

(B) Specific frequency of change or use — “as needed” or “prn” orders are not acceptable;

(C) Number of units;

(D) Length of need: Example: An order for surgical dressings might specify one 4” x 4” hydrocolloid dressing which is changed one to two times per week for one month or until the ulcer heals;

(b) For orthoses: If a custom-fabricated orthosis is ordered by the practitioner, this must be clearly indicated on the written order;

(c) Length of need:

(A) If the coverage criteria in a rule specifies length of need; or,

(B) If the order is for a rental item;

(d) Any other medical documentation required by rule.

(13) For repairs: Labor for repairs, parts for durable medical equipment (DME) repairs and replacement parts for DME (e.g., batteries) do not require a written order.

(14) A new order is required:

(a) When required by Medicare (for a Medicare covered service) (www.cignamedicare.com); or,

(b) When there is a change in the original order for an item; or,

(c) When an item is permanently replaced; or,

(d) When indicated by the prescribing practitioner;

(A) A new order is required when an item is being replaced because the item is worn or the client’s condition has changed; and,

(B) The provider’s records should also include client-specific information regarding the need for the replacement item; and,

(C) This information should be maintained in the provider’s files and be available to the Division on request; and,

(D) A new order is required before replacing lost, stolen or irreparably damaged items to reaffirm the medical appropriateness of the item;

(e) When there is a change of DMEPOS provider: In cases where two or more providers merge, the resultant provider should make all reasonable attempts to secure copies of all active CMN's and written orders from the provider(s) purchased. This document should be kept on file by the resultant provider for future presentation to the Division, if requested;

(f) On a regular or specific basis (even if there is no change in the order) only if it is so specified in a particular rule.

(15) A provider is required to maintain and provide (when required by a particular rule) legible copies of facsimile image and electronic transmissions of orders.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-122-0205

Respiratory Assist Devices

(1) As referenced in this policy, non-invasive positive pressure respiratory assistance (NPPRA) is the administration of positive air pressure, using a nasal and/or oral mask interface which creates a seal, avoiding the use of more invasive airway access (e.g., tracheostomy).

(2) Indications and Coverage — General:

(a) The "treating prescribing practitioner" must be one who is qualified by virtue of experience and training in non-invasive respiratory assistance, to order and monitor the use of respiratory assist devices (RAD);

(b) For the purpose of this policy, polysomnographic studies must be performed in a sleep study laboratory, and not in the home or in a mobile facility. The sleep study laboratory must comply with all applicable state regulatory requirements;

(c) For the purpose of this policy, arterial blood gas, sleep oximetry and polysomnographic studies may not be performed by a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider. For purposes of this policy's coverage and payment guidelines, a DMEPOS provider is not considered a qualified provider or supplier of these tests;

(d) If there is discontinuation of usage of E0470 or E0471 device at any time, the provider is expected to ascertain this, and stop billing for the equipment and related accessories and supplies.

(3) Coverage criteria for E0470 and E0471 devices – Table 122-0205-1.

(4) Documentation:

(a) The following documentation must be submitted with the request for prior authorization (PA) and the original kept on file by the provider:

(A) An order for all equipment and accessories including the client's diagnosis, an ICD-910-CM code signed and dated by the treating prescribing practitioner;

(B) Summary of events from the polysomnogram, if required in this rule under the indications and coverage section or Table 122-0205-1;

(C) Arterial blood gas results, if required under the indications and coverage section or Table 122-0205-1;

(D) Sleep oximetry results, if required under the indications and coverage section or Table 122-0205-1;

(E) Treating prescribing practitioner statement regarding medical symptoms characteristic of sleep-associated hypoventilation, including, but not limited to daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, and dyspnea;

(F) Other treatments that have been tried and failed. To be submitted in addition to the above at the fourth month review;

(b) A copy of the Evaluation of Respiratory Assist Device (Division 2461) completed and signed by the client, family member or caregiver;

(c) Clients currently using BiPapS and BiPap ST are not subject to the new criteria.

(5) **Table 122-0205-1**, Respiratory Assist Devices.

(6) **Table 122-0205-2**, Procedure Codes.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-122-0330

Power-Operated Vehicle

(1) Indications and limitations of coverage and medical appropriateness:

(a) The Division of Medical Assistance Programs (Division) may cover a power-operated vehicle (POV) when all of the following criteria are met:

(A) The client has a mobility limitation that significantly impairs their ability to accomplish mobility-related activities of daily living (MRADLs) ; places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or the client is unable to sustain safely the performance of MRADLs throughout the course of a regular day. See OAR 410-122-0010 Definitions for complete definition of MRADLs;

(B) An appropriately fitted cane or walker cannot resolve the client's mobility limitation;

(C) The client does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day:

(i) Assessment of upper extremity function should consider limitations of strength, endurance, range of motion, or coordination, presence of pain, and deformity or absence of one or both upper extremities;

(ii) An optimally-configured manual wheelchair features an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories;

(D) The client has sufficient strength, postural stability, or other physical or mental capabilities needed to safely operate a POV in the home;

(E) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for the operation of the POV being requested;

(F) Use of a POV will significantly improve the client's ability to move within the home to the areas customarily used for their MRADLs to allow completion of these activities within a reasonable time frame;

(G) The client is willing to use the requested POV in the home, and the client will use it on a regular basis in the home;

(H) The Division does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup POVs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if the POV meets the same need, custom colors, and wheelchair gloves;

(b) For a POV to be covered, the treating physician or nurse practitioner must conduct a face-to-face examination of the client before writing the order:

(A) The durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider must receive a written report of this examination within 45 days after the face-to-face examination and prior to delivery of the device.

(B) When this examination is performed during a hospital or nursing facility stay, the DMEPOS provider must receive the report of the examination within 45 days after date of discharge;

(C) The physician or nurse practitioner may refer the client to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. This person may not be an employee of the DMEPOS provider or have any direct or indirect financial relationship, agreement or contract with the DMEPOS provider. When the DMEPOS provider is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination:

(i) If the client was referred to the PT/OT before being seen by the physician or nurse practitioner, then once the physician or nurse practitioner has received and reviewed the written report of this examination, the physician or nurse practitioner must see the client and perform any additional examination that is needed. The physician's or nurse practitioner's report of the visit should state concurrence or any disagreement with the PT/OT examination. In this situation, the physician or nurse practitioner must provide the DMEPOS provider with a copy of both examinations within 45 days of the face-to-face examination with the physician or nurse practitioner;

(ii) If the physician or nurse practitioner examined the client before referring the client to a PT/OT, then again in person after receiving the report of the PT/OT examination, the 45-day period begins on the date of that second physician or nurse practitioner visit. However, it is

also acceptable for the physician or nurse practitioner to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician or nurse practitioner must send a copy of the note from his/her initial visit to evaluate the client plus the annotated, signed, and dated copy of the PT/OT examination to the DMEPOS provider. The 45-day period begins when the physician or nurse practitioner signs and dates the PT/OT examination;

(iii) If the POV is a replacement of a similar item that was previously covered by the Division or when only POV accessories are being ordered and all other coverage criteria in this rule are met, a face-to-face examination is not required;

(c) The Division may authorize a new POV when a client's existing POV is no longer medically appropriate; or repair and/or modifications to the POV exceed replacement costs;

(d) If a client has a medically appropriate POV regardless of payer, the Division will not reimburse for another POV;

(e) The cost of the POV includes all options and accessories that are provided at the time of initial purchase, including but not limited to batteries, battery chargers, seating systems, etc.;

(f) Reimbursement for the POV includes all labor charges involved in the assembly of the POV and all covered additions or modifications. Reimbursement also includes support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education and on-going assistance with use of the POV;

(g) If a client-owned POV meets coverage criteria, medically appropriate replacement items, including but not limited to batteries, may be covered;

(h) If a POV is covered, a manual or power wheelchair provided at the same time or subsequently will usually be denied as not medically appropriate;

(i) The Division will cover one month's rental of a POV if a client-owned POV is being repaired;

(j) The following services are not covered:

(A) POV for use only outside the home; and

(B) POV for a nursing facility client.

(2) Coding guidelines:

(a) Codes K0800 — K0802 are used only for POVs that can be operated inside the home;

(b) Codes K0800 — K0802 are not used for a manual wheelchair with an add-on tiller control power pack;

(c) A replacement item, including but not limited to replacement batteries, should be requested using the specific wheelchair option or accessory code if one exists (see 410-122-0340, Wheelchairs Options/Accessories). If a specific code does not exist, use code K0108 (wheelchair component or accessory, not otherwise specified);

(d) For guidance on correct coding, DMEPOS providers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor by the Centers for Medicare and Medicaid Services. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information.

(3) Documentation requirements: Submit all of the following documentation with the prior authorization (PA) request:

(a) A copy of the written report of the face-to-face examination of the client by the physician or nurse practitioner:

(A) The report must include information related to the following:

(i) This client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(iii) Why a manual wheelchair can't meet this client's mobility needs in the home;

(iv) This client's physical and mental abilities to operate a POV (scooter) safely in the home:

(I) Besides a mobility limitation, if other conditions exist that limit a client's ability to participate in MRADLs, how these conditions will be ameliorated or compensated;

(II) How these other conditions will be ameliorated or compensated sufficiently such that the additional provision of mobility assistive equipment (MAE) will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home.

(B) The face-to-face examination should provide pertinent information about the following elements, but may include other details. Only relevant elements need to be addressed:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, manual wheelchair, POV, or power wheelchair and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Presence of abnormal tone or deformity of arms, legs or trunk;

(IV) Neck, trunk, and pelvic posture and flexibility;

(V) Sitting and standing balance;

(v) Functional assessment — any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and power mobility device;

(II) Walking around their home — to bathroom, kitchen, living room, etc. — provide information on distance walked, speed, and balance;

(C) Although a client who qualifies for coverage of a POV may use that device outside the home, because the Division's coverage of a POV is determined solely by the client's mobility needs within the home, the examination must clearly distinguish the client's abilities and needs within the home from any additional needs for use outside the home;

(b) The physician's or nurse practitioner's written order, received by the DMEPOS provider within 30 days after the physician's or nurse practitioner's face-to-face examination, which includes all of the following elements:

(A) Client's name;

(B) Description of the item that is ordered. This may be general — e.g., "POV" or "power mobility device" — or may be more specific:

(i) If this order does not identify the specific type of POV that is being requested, the DMEPOS provider must clarify this by obtaining another written order which lists the specific POV that is being ordered and any options and accessories requested;

(ii) The items on this order may be entered by the DMEPOS provider. This subsequent order must be signed and dated by the treating physician or nurse practitioner, received by the DMEPOS provider and submitted to the authorizing authority, but does not have to be received within 45 days following the face-to-face examination.

(C) Most significant ICD-910 diagnosis code that relates specifically to the need for the POV;

(D) Length of need;

(E) Physician's or nurse practitioner's signature;

(F) Date of physician's or nurse practitioner's signature;

(c) For all requested equipment and accessories, include the manufacturer's name, product name, model number, standard features, specifications, dimensions and options;

(d) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including the age of the equipment and why it can't be grown or modified, if applicable;

(e) A written evaluation of the client's living quarters, performed by the DMEPOS provider. This assessment must support that the client's home can accommodate and allow for the effective use of a POV, including, but is not limited to, evaluation of door widths, counter/table height, accessibility (e.g., ramps), electrical service, etc; and

(f) All HCPCS to be billed on this claim (both codes that require authorization and those that do not require authorization); and

(g) Any additional documentation that supports indications of coverage are met as specified in this rule;

(h) The above documentation must be kept on file by the DMEPOS provider;

(i) Documentation that the coverage criteria have been met must be present in the client's medical record. This documentation and any additional medical information from the DMEPOS provider must be made available to the Division on request.

(4) Billing:

(a) Procedure Codes:

(A) K0800 Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds — PA;

(B) K0801 Power operated vehicle, group 1 heavy duty, patient weight capacity, 301 to 450 pounds — PA;

(C) K0802 Power operated vehicle, group 1 very heavy duty, patient weight capacity, 451 to 600 pounds — PA;

(b) The Division will purchase, rent and repair;

(c) Item considered purchased after 13 months of rent.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-122-0400

Pressure Reducing Support Surfaces

(1) Indications and limitations of coverage and medical appropriateness:

(a) Group 1 (A4640, E0180–E0182, E0184–E0189, and E0196–E0199):

(A) The Division of Medical Assistance Programs (Division) may cover a Group 1 support surface when the client meets:

(i) Criterion (I), or;

(ii) Criteria (II) or (III) and at least one of criteria (IV)–(VII):

(I) Completely immobile — i.e., client cannot make changes in body position without assistance;

(II) Limited mobility — i.e., client cannot independently make changes in body position significant enough to alleviate pressure;

(III) Any stage pressure ulcer on the trunk or pelvis;

(IV) Impaired nutritional status;

(V) Fecal or urinary incontinence;

(VI) Altered sensory perception;

(VII) Compromised circulatory status;

(B) The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provider must provide a support surface in which the client does not "bottom out";

(C) The Division does not cover foam overlays or mattresses without a waterproof cover, since these are not considered durable;

(D) The Division does not cover pressure reducing support surfaces for the prevention of pressure ulcers or pain control;

(E) The allowable rental fee includes all equipment, supplies and services for the effective use of the pressure reducing support surface;

(b) Group 2 (E0193, E0277, and E0371–E0373):

(A) A Group 2 support surface may be covered for up to an initial three month rental period when the client meets:

(i) Criterion (I) and (II) and (III), or;

(ii) Criterion (IV), or;

(iii) Criterion (V) and (VI);

(I) Multiple stage II pressure ulcers located on the trunk or pelvis; ~~(ICD-9 707.02–707.05)~~;

(II) Client has been on a comprehensive ulcer treatment program for at least the past month which includes the following: use of an appropriate Group 1 support surface; education of the client, if appropriate, and caregiver on the prevention and/or management of pressure ulcers; regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer); appropriate turning and positioning;

appropriate wound care (for a stage II, III, or IV ulcer); appropriate management of moisture/incontinence; and nutritional assessment and intervention consistent with the overall plan of care;

(III) The ulcers have worsened or remained the same over the past month;

(IV) Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (~~HCD-9 707.02-707.05~~); A large wound is generally any wound of eight square centimeters (length x width) or more. Individual client circumstances may be weighed. Undermining and/or tunneling, anatomic location on the body and the size of the client may be taken into account;

(V) Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) (~~HCD-9 707.02-707.05~~);

(VI) The client has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days);

(B) The DMEPOS provider must provide a support surface in which the patient does not "bottom out";

(C) When a Group 2 surface is requested following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery

(D) The Division may cover continued use of a Group 2 support surface if healing continues;

(E) The Division does not cover pressure reducing support surfaces for the prevention of pressure ulcers or pain control;

(F) The allowable rental fee includes all equipment, supplies and services for the effective use of the pressure reducing support surface;

(c) Division may consider coverage for bariatric pressure reducing support surfaces only coded as E1399 (durable medical equipment, miscellaneous) for a client residing in a nursing facility, subject to service limitations of Division rules, only when the following requirements are met:

(A) The client meets the conditions of coverage as specified in this rule; and

(B) The bariatric pressure reducing support surface has been assigned code E1399 by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor;

(d) Group 3: Air-fluidized beds (E0194) are not covered.

(2) Definitions for Group 1 and Group 2:

(a) Bottoming out: Finding that an outstretched hand, placed palm up between the undersurface of the overlay or mattress and the patient's bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion should be tested with the client in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the side-lying position;

(b) Plan of care: Written guidelines developed to identify specific problems and needs of the client and interventions/regimen necessary to assist the client to achieve optimal health potential. Developing the plan of care includes establishing measurable client and nursing goals with time lines and determining nursing/caregiver/other discipline-assigned interventions to meet care objectives;

(c) The staging of pressure ulcers used in this rule is as follows:

(A) Stage I — Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues;

(B) Stage II — Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater;

(C) Stage III — Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue;

(D) Stage IV — Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers;

(3) Guidelines:

(a) Group 1:

(A) Codes E0185 and E0197–E0199 termed "pressure pad for mattress" describe non-powered pressure reducing mattress overlays and are designed to be placed on top of a standard hospital or home mattress;

(B) A gel/gel-like mattress overlay (E0185) is characterized by a gel or gel-like layer with a height of two inches or greater;

(C) An air mattress overlay (E0197) is characterized by interconnected air cells having a cell height of three inches or greater that are inflated with an air pump;

(D) A water mattress overlay (E0198) is characterized by a filled height of three inches or greater;

(E) A foam mattress overlay (E0199) is characterized by all of the following:

(i) Base thickness of two inches or greater and peak height of three inches or greater if it is a convoluted overlay (e.g., egg crate) or an overall height of at least three inches if it is a non-convoluted overlay; and

(ii) Foam with a density and other qualities that provide adequate pressure reduction; and

(iii) Durable, waterproof cover;

(F) Codes E0184, E0186, E0187 and E0196 describe non-powered pressure reducing mattresses;

(G) A foam mattress (E0184) is characterized by all of the following:

(i) Foam height of five inches or greater;

(ii) Foam with a density and other qualities that provide adequate pressure reduction;

(iii) Durable, waterproof cover; and

(iv) Can be placed directly on a hospital bed frame;

(H) An air, water or gel mattress (E0186, E0187, E0196) is characterized by all of the following:

(i) Height of five inches or greater of the air, water, or gel layer (respectively);

(ii) Durable, waterproof cover; and

(iii) Can be placed directly on a hospital bed frame;

(I) Codes E0180, E0181, E0182, and A4640 describe powered pressure reducing mattress overlay systems (alternating pressure or low air loss) and are characterized by all of the following:

(i) An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay;

(ii) Inflated cell height of the air cells through which air is being circulated is 2 inches or greater; and

(iii) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate client lift, reduce pressure and prevent bottoming out;

(J) Alternating pressure mattress overlays or low air loss mattress overlays are coded using codes E0180, E0181, E0182, and A4640;

(K) Code A4640 or E0182 may only be billed when they are provided as replacement components for a client-owned E0180 or E0181 mattress overlay system;

(L) A Column II code is included in the allowance for the corresponding Column I code when provided at the same time: Column I (Column II), E0180 (A4640, E0182), E0181 (A4640, E0182);

(b) Group 2:

(A) Code E0277 describes a powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) which is characterized by all of the following:

(a) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress;

(b) Inflated cell height of the air cells through which air is being circulated is five inches or greater;

(c) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out;

(d) A surface designed to reduce friction and shear; and

(e) Can be placed directly on a hospital bed frame;

(B) Code E0193 describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics defined above;

(C) Code E0371 describes an advanced non-powered pressure-reducing mattress overlay which is characterized by all of the following:

(i) Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out;

(ii) Total height of three inches or greater;

(iii) A surface designed to reduce friction and shear; and

(iv) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces;

(D) Code E0372 describes a powered pressure reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) which is characterized by all of the following:

(i) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay;

(ii) Inflated cell height of the air cells through which air is being circulated is 3 ? inches or greater;

(iii) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate patient lift, reduce pressure and prevent bottoming out; and

(iv) A surface designed to reduce friction and shear;

(E) Code E0373 describes an advanced non-powered pressure reducing mattress which is characterized by all of the following:

(i) Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out;

(ii) Total height of five inches or greater;

(iii) A surface designed to reduce friction and shear;

(iv) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces; and

(v) Can be placed directly on a hospital bed frame;

(F) The only products that may be coded and billed using code E0371 or E0373 are those products for which a written coding determination specifying the use of these codes has been made by PDAC;

(G) Alternating pressure mattresses and low air loss mattresses are coded using code E0277;

(H) Products containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multi-layer product). For example, a product with three powered air cells on top of a three foam base would be coded as a powered overlay (code E0180 or E0181), not as a powered mattress (E0277).

(4) Documentation requirements: Submit the following information with the prior authorization request:

(a) Initial Requests:

(A) For all pressure reducing support surfaces, other than a Group I for a completely immobile client or a Group 2 surface following a myocutaneous flap or skin graft:

(i) An order for each item requested, signed and dated by the attending physician;

(ii) Documentation that supports conditions of coverage are met as specified in this rule;

(iii) A plan of care which has been established by the client's physician or home care nurse (by the RN resident care manager for a client in a nursing facility), which generally includes the following: Education of the client, if appropriate, and caregiver on the prevention and/or management of pressure ulcers;

(II) Regular assessment by a nurse, physician, or other licensed healthcare practitioner;

(III) Appropriate turning and positioning including the number of hours per 24-period that the client will utilize the support surface;

(IV) Appropriate wound care (for a stage II, III, or IV ulcer);

(V) Appropriate management of moisture/incontinence;

(VI) Nutritional assessment and intervention consistent with the overall plan of care by a licensed healthcare practitioner (by a registered dietitian for a client in a nursing facility) within the last 90 days;

(VII) Client's weight and height (approximation is acceptable, if unable to obtain);

(VIII) Description of all pressure ulcers, which includes number, locations, stages, sizes and dated photographs;

(iv) Lab reports, if relevant;

(v) Other treatments and products that have been tried and why they were ineffective; Interventions and goals for stepping down the intensity of support surface therapy;

(vi) For pressure ulcers on extremities, why pressure cannot be relieved by other methods;

(B) For a Group 1 surface for a completely immobile client:

(a) An order for each item requested, signed and dated by the attending physician;

(b) A plan of care which has been established by the client's physician or home care nurse (by the RN resident care manager for a client in a nursing facility), which generally includes the following:

(I) Education of the client, if appropriate, and caregiver on the prevention of pressure ulcers;

(ii) Regular assessment by a nurse, physician, or other licensed healthcare practitioner

(iii) Appropriate turning and positioning including the number of hours per 24-period that the client will utilize the support surface;

(iv) Appropriate management of moisture/incontinence, if appropriate;

(C) For a Group 2 surface following a myocutaneous flap or skin graft:

(i) An order for each item requested, signed and dated by the treating physician;

(ii) Operative report;

(iii) Hospital discharge summary;

(iv) Plan of care;

(F) Required documentation may not be completed by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider or anyone in a financial relationship of any kind with the DMEPOS provider;

(G) Medical records must corroborate that all criteria in this rule are met when dispensing and billing for an item in Table 122-0400-1 and Table-122-400-2;

(H) Medical records must be kept on file by the DMEPOS provider and made available to the Division upon request;

(b) Subsequent Requests: May be authorized contingent on progress towards healing:

(A) For all pressure reducing support surfaces, other than a Group I surface for a completely immobile client or a Group 2 surface following a myocutaneous flap or skin graft:

(i) Progress notes from the attending physician;

(ii) Description of all pressure ulcers, including progress towards healing, by a licensed healthcare practitioner (by the RN resident care manager for a client in a nursing facility) which includes number, locations, stages, sizes and dated photographs;

(iii) Current plan of care;

(iv) Any other relevant documentation;

(B) For a Group I surface for a completely immobile client:

(i) Progress notes from the attending physician;

(ii) Current plan of care;

(iii) Any other relevant documentation;

(C) For a Group 2 surface following a myocutaneous flap or skin graft:

(i) Progress notes from the attending physician;

(ii) Current plan of care;

(iii) Any other relevant documentation.

(4) **Table 122-0400-1** — Group 1.

(5) **Table 122-0400-2** — Group 2.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-122-0662

Ankle-Foot Orthoses and Knee-Ankle-Foot Orthoses

(1) Indications and limitations of coverage and medical appropriateness: The Division of Medical Assistance Programs (Division) may cover some ankle-foot orthotics (AFOs) and knee-ankle-foot Orthotics (KAFOs) and related services for a covered condition, for this

episode, when the covered device has not been billed to the Division with a Current Procedure Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code or diagnosis code by any other healthcare provider, and in addition specifically for:

(a) AFOs not used during ambulation: A static AFO (L4396) may be covered when (A)-(E) are met:

(A) The client has a plantar flexion contracture of the ankle (Internal Classification of Diseases (ICD)-10 diagnosis code ~~718.47~~ M24.571, M24.572) with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a nonfixed contracture);

(B) There is a reasonable expectation of the ability to correct the contracture;

(C) The contracture is interfering or expected to interfere significantly with the client's functional abilities;

(D) The static AFO is used as a component of a therapy program that includes active stretching of the involved muscles and/or tendons;

(E) The pre-treatment passive range of motion is measured with a goniometer and an appropriate stretching program carried out by professional staff (in a nursing facility) or caregiver (at home) is documented in the client's treatment plan;

(b) AFOs and KAFOs used during ambulation:

(A) AFOs described by codes L1900, L1902-L1990, L2106-L2116, L4350, L4360 and L4386 with weakness or deformity of the foot and ankle requiring stabilization for medical reasons and with potential to benefit functionally;

(B) KAFOs described by codes L2000-L2038, L2126-L2136 and L4370 when conditions of coverage are met for an AFO and additional knee stability is required:

(C) AFOs and KAFOs that are molded-to-patient model, or custom-fabricated when basic coverage criteria for an AFO or KAFO are met and one of the following criteria is met:

(i) The client could not be fit with a prefabricated AFO;

(ii) The condition necessitating the orthotic is expected to be permanent or of longstanding duration (more than six months);

(iii) There is a need to control the knee, ankle or foot in more than one plane;

(iv) The client has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury;

(v) The client has a healing fracture that lacks normal anatomical integrity or anthropometric proportions;

(c) No more than one replacement interface (L4392) may be covered every six months for a covered static AFO;

(d) Evaluation of the client, measurement and/or casting and fitting of the orthotic are included in the allowance for the orthotic;

(e) Repairs/Replacement:

(A) Repairs to a covered orthotic due to wear or to accidental damage when necessary to make the orthotic functional. If the expense for repairs exceeds the estimated expense of providing another entire orthot, no payment will be made for the amount in excess;

(B) Replacement of a complete orthotic or component of an orthotic due to loss, significant change in the client's condition or irreparable accidental damage if the device is still medically appropriate and conditions of coverage are met;

(C) L4205 (Repair of orthotic device, labor component, per 15 minutes):

(i) May only bill for the actual time involved in the repair of an orthotic;

(ii) May not use this code for any labor involved in the evaluation, fabrication or fitting of a new or full replacement orthotic;

(iii) Use for the labor component of repair of a previously provided orthotic;

(D) Labor Allowance:

(i) Included in the replacement of an orthotic component coded with a specific L code;

(ii) Not included in the replacement of an orthotic component coded with L4210;

(E) Replacement items with specific HCPCS codes:

(i) Use L4392 and L4394 for replacement soft interfaces used with ankle contracture orthotics or foot drop splints;

(ii) Use L2999 (Lower extremity orthotics, not otherwise specified) for replacement components that do not have a specific HCPCS code;

(iii) Addition codes L4002 — L4130, L4392 for replacement components are not payable at initial issue of a base orthotic;

(f) The codes specified in this rule may be covered for a client residing in a nursing facility;

(g) Quantities of supplies greater than those described in the policy as the usual maximum amounts only when supported by documentation clearly and maximum amounts only when supported by documentation clearly and specifically explaining the medical appropriateness of the excess quantities.

(2) Exclusions: The following services are not covered;

(a) A static AFO and replacement interface for:

(A) A fixed contracture; or

(B) A foot drop without an ankle flexion contracture;

(C) When used solely for the prevention or treatment of a heel pressure ulcer;

(b) A component of a static AFO that is used to address positioning of the knee or hip;

(c) A foot drop splint/recumbent positioning device (L4398) or replacement interface (L4394) for a non-ambulatory client when used solely for the prevention or treatment of a pressure ulcer;

(d) An AFO or KAFO and any related addition for an ambulatory client when used solely for treatment of edema and/or prevention or treatment of a pressure ulcer;

(e) Walking boots used primarily to relieve pressure, especially on the sole of the foot or used solely for the prevention or treatment of a pressure ulcer;

(f) Elastic support garments (L1901);

(g) Socks (L2840, L2850) used in conjunction with orthotics;

(h) Replacement components (e.g., soft interfaces) that are provided on a routine basis, without regard to whether the original item is worn out;

(i) A foot pressure off-loading/supportive device (A9283);

(j) L coded additions to AFOs and KAFOs (L2180-L2550, L2750-L2768, L2780-L2830) if either the coverage criteria for the base orthotic is not met or the specific addition is not medically appropriate.

(3) Coding Guidelines:

(a) A prefabricated orthotic is one that is manufactured in quantity without a specific client in mind. A prefabricated orthotic may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific client (i.e., custom fitted). An orthotic that is assembled from prefabricated components is considered prefabricated. Any orthotic that does not meet the definition of a custom-fabricated orthotic is considered prefabricated;

(b) A custom-fabricated orthotic is individually made for a specific client starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item;

(c) A molded-to-patient model orthotic is a particular type of custom-fabricated orthotic in that an impression of the specific body part is made (by means of a plaster cast, computer-aided design and computer-aided manufacturing (CAD-CAM) technology, etc.). This impression is used to make a positive model (of plaster or other material) of the body part. The orthotic is then molded on this positive model;

(d) Ankle-foot orthotics extend well above the ankle (usually to near the top of the calf) and are fastened around the lower leg above the ankle. These features distinguish them from foot orthotics that are shoe inserts that do not extend above the ankle. A nonambulatory ankle-foot orthotic may be either an ankle contracture splint, night splint or a foot drop splint;

(e) A static AFO (L4396) is a prefabricated ankle-foot orthotic that has all of the following characteristics:

(A) Designed to accommodate an ankle with a plantar flexion contracture up to 45°;

(B) Applies a dorsiflexion force to the ankle;

(C) Used by a client who is minimally ambulatory or nonambulatory;

(D) Has a soft interface;

(f) A foot drop splint/recumbent positioning device (L4398) is a prefabricated ankle-foot orthotic that has all of the following characteristics:

(A) Designed to maintain the foot at a fixed position of 0° (i.e., perpendicular to the lower leg);

(B) Not designed to accommodate an ankle with a plantar flexion contracture;

(C) Used by a client who is nonambulatory;

(D) Has a soft interface.

(4) HCPCS Modifiers:

(a) EY — No physician or other licensed health care provider order for this item or service;

(b) GY — Item or service statutorily excluded or does not meet the definition of any Medicare benefit:

(A) If an AFO or a KAFO is used solely for the treatment of edema and/or for the prevention or treatment of a pressure ulcer, the GY modifier must be added to the base code and any related additional code;

(B) If a walking boot (L4360, L4386), static AFO (L4396) or foot drop splint/recumbent positioning device (L4398) is used solely for the prevention or treatment of a pressure ulcer, the GY modifier must be added to the base code and to the code for the replacement liner (L4392, L4394);

(C) When the GY modifier is added to a code there must be a short narrative statement indicating why the GY modifier was used — e.g., “used to prevent pressure ulcer” or “used to treat pressure ulcer” or “used to treat edema”. This statement must be entered in the narrative field of an electronic claim or attached to a hard copy claim;

(c) KX — Requirements specified in the medical policy have been met. The provider must add a KX modifier to the AFO/KAFO base and additional codes only if all the coverage criteria of this policy have been met and evidence of such is retained in the provider's files;

(d) LT — Left Side; RT — Right Side:

(A) The right (RT) and left (LT) modifiers must be used with orthotic base codes, additions and replacement parts;

(B) When the same code for bilateral items (left and right) is billed on the same date of service, bill both items on the same claim line using the LTRT modifiers and 2 units of service.

(5) Documentation Requirements:

(a) L2999 is the only code in this rule that requires prior authorization (PA): For a PA request, submit documentation for review that supports conditions of coverage as specified in this rule are met, including the plan of care, if applicable;

(b) For services that do not require PA: Documentation from the medical record that supports conditions of coverage as specified in this rule are met must be kept on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider;

(c) Prior to billing for each new or full replacement item, the DMEPOS provider must first have received a completed written, signed and dated physician's order that includes:

(A) The treating diagnosis code that justifies the need for the orthotic device;

(B) Detailed description of the item including all options or additional features;

(C) The unique features of the base code plus every addition that will be billed on a separate claim line;

(d) For custom-fabricated orthotics, documentation must support the medical appropriateness of that type device rather than a prefabricated orthotic;

(e) For L2999:

(A) The request for PA must include the following information:

(i) A narrative description of the item (for custom fabricated items); or

(ii) The manufacturer's name and model name/number (for pre-fabricated items); and

(iii) Justification of medical appropriateness for the item;

(iv) For replacement components, a HCPCS code or the manufacturer's name and model name/number of the base orthotic;

(v) The manufacturer's name and model name/number must be entered in the narrative field of an electronic claim;

(f) Repair of orthotic devices:

(A) A physician's order is not required;

(B) A detailed description of the reason for the repair, part that is being repaired or replaced must be on file with the DMEPOS provider;

(C) The following information must be entered in the narrative field of an electronic claim:

(i) L4210 must include a description of each item that is billed;

(ii) L4205 must include an explanation of what is being repaired;

(D) All codes for repairs of orthotics billed with the same date of service must be submitted on the same claim;

(g) The provider must include the ICD-910 diagnosis code for the underlying condition on the claim for a static AFO (L4396) or replacement interface material (L4392);

(h) All codes for orthotics billed with the same date of service must be submitted on the same claim;

(i) When billing for quantities of supplies greater than those described in the policy as the usual maximum amounts, there must be documentation in the client's medical record supporting the medical appropriateness for the higher utilization;

(j) The client's medical record must support the medical appropriateness for items and all additions billed to the Division and this documentation must be made available to the Division on request.

(5) Table 122-0662

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

**DIVISION 123
DENTAL/DENTURIST SERVICES**

**410-123-1260
OHP Plus Dental Benefits**

(1) GENERAL:

(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT):

(A) Refer to Code of Federal Regulations (42 CFR 441, Subpart B) and OAR chapter 410, division 120 for definitions of the EPSDT program, eligible clients, and related services. EPSDT dental services include, but are not limited to:

(i) Dental screening services for eligible EPSDT individuals; and

(ii) Dental diagnosis and treatment that is indicated by screening at as early an age as necessary, needed for relief of pain and infections, restoration of teeth, and maintenance of dental health;

(B) Providers shall provide EPSDT services for eligible Division of Medical Assistance Programs (Division) clients according to the following documents:

(i) The Dental Services Program administrative rules (OAR chapter 410, division 123), for dentally appropriate services funded on the Oregon Health Evidence Review Commission's Prioritized List of Health Services (Prioritized List); and

(ii) The "Oregon Health Plan (OHP) — Recommended Dental Periodicity Schedule," dated January 1, 2010, incorporated in rule by reference and posted on the Division website in the Dental Services Provider Guide document at www.oregon.gov/oha/healthplan/Pages/dental.aspx;

(b) Restorative, periodontal, and prosthetic treatments:

(A) Documentation shall be included in the client's charts to support the treatment. Treatments shall be consistent with the prevailing standard of care and may be limited as follows:

(i) When prognosis is unfavorable;

(ii) When treatment is impractical;

(iii) A lesser-cost procedure would achieve the same ultimate result; or

(iv) The treatment has specific limitations outlined in this rule;

(B) Prosthetic treatment, including porcelain fused to metal crowns, are limited until rampant progression of caries is arrested and a period of adequate oral hygiene and periodontal stability is demonstrated; periodontal health needs to be stable and supportive of a prosthetic.

(2) ENHANCED ORAL HEALTH SERVICES IN PRIMARY CARE SETTINGS:

(a) Topical fluoride treatment:

(A) For children under 19 years of age, topical fluoride varnish may be applied by a licensed medical practitioner during a medical visit. Providers must bill:

(i) The Division directly when the client is fee-for-service (FFS), is enrolled in a Coordinated Care Organization (CCO) that does not include integrated medical and dental services, or is enrolled in a PHP that does not include integrated medical and dental services;

(ii) The client's CCO if the client is enrolled in a CCO that includes integrated medical and dental services;

(iii) Using a professional claim format with the appropriate Current Dental Terminology (CDT) code D1206-Topical Fluoride Varnish;

(B) Topical fluoride treatment from a medical practitioner counts toward the overall maximum number of fluoride treatments, as described in subsection (4) of this rule;

(b) Assessment of a patient:

(A) For children under six years of age, CDT code D0191-Assessment of a Patient is covered as an enhanced oral health service in medical settings;

(B) For reimbursement in a medical setting, D0191-Assessment of a patient must include all of the following components:

(i) Caries risk assessment using a standardized tool endorsed by Oregon Oral Health Coalition, the American Dental Association, the American Academy of Pediatric Dentistry, or the American Academy of Pediatrics;

(ii) Anticipatory guidance and counseling with the client's caregiver on good oral hygiene practices and nutrition;

(iii) Referral to a dentist in order to establish a dental home;

(iv) Documentation in medical chart of risk assessment findings and service components provided;

(C) For reimbursement, the performing provider must meet all of the following criteria:

(i) Be a physician (MD or DO), an advance practice nurse, or a licensed physician assistant; and

(ii) Hold a certificate of completion from one of the following approved training programs within the previous three years:

(I) Smiles for Life; or

(II) First Tooth through the Oregon Oral Health Coalition;

(D) For reimbursement, the medical practitioners must bill:

(i) The Division directly when the client is fee-for-service (FFS), is enrolled in a Coordinated Care Organization (CCO) that does not include integrated medical and dental services, or is enrolled in a PHP that does not include integrated medical and dental services;

(ii) The client's CCO if the client is enrolled in a CCO that includes integrated medical and dental services;

(iii) Using a professional claim format with the appropriate CDT code (D0191-Assessment of a Patient);

(E) D0191 Assessment of a Patient may be reimbursed under this subsection up to a maximum of once every 12 months;

(F) D0191 Assessment of a Patient from a medical practitioner does not count toward the maximum number of CDT code D0191-Assessment of a Patient services performed by a dental practitioner described in subsection three (3) of this rule;

(c) For tobacco cessation services provided during a medical visit, follow criteria outlined in OAR 410-130-0190;

(3) DIAGNOSTIC SERVICES:

(a) Exams:

(A) For children under 19 years of age:

(i) The Division shall reimburse exams (billed as CDT codes D0120, D0145, D0150, or D0180) a maximum of twice every 12 months with the following limitations:

(I) D0150: once every 12 months when performed by the same practitioner;

(II) D0150: twice every 12 months only when performed by different practitioners;

(III) D0180: once every 12 months;

(ii) The Division shall reimburse D0160 only once every 12 months when performed by the same practitioner;

(B) For adults 19 years of age and older, the Division shall reimburse exams (billed as CDT codes D0120, D0150, D0160, or D0180) once every 12 months;

(C) For problem focused exams (urgent or emergent problems), the Division shall reimburse D0140 for the initial exam. The Division shall reimburse D0170 for related problem-focused follow-up exams. Providers must not bill D0140 and D0170 for routine dental visits;

(D) The Division only covers oral exams performed by medical practitioners when the medical practitioner is an oral surgeon;

(E) As the American Dental Association's Current Dental Terminology (CDT) codebook specifies, the evaluation, diagnosis, and treatment planning components of the exam are the responsibility of the dentist. The Division may not reimburse dental exams when performed by a dental hygienist (with or without an expanded practice permit);

(b) Assessment of a patient (D0191):

(A) When performed by a dental practitioner, the Division shall reimburse:

(i) If performed by a dentist outside of a dental office;

(ii) If performed by a dental hygienist with an expanded practice dental hygiene permit;

(iii) Only if an exam (D0120-D0180) is not performed on the same date of service. Assessment of a patient (D0191) is included as part of an exam (D0120-D0180);

(iv) For children under 19 years of age, a maximum of twice every 12 months; and

(v) For adults age 19 and older, a maximum of once every 12 months;

(B) An assessment does not take the place of the need for oral evaluations/exams;

(c) Radiographs:

(A) The Division shall reimburse for routine radiographs once every 12 months;

(B) The Division shall reimburse bitewing radiographs for routine screening once every 12 months;

(C) The Division shall reimburse a maximum of six radiographs for any one emergency;

(D) For clients under age six, radiographs may be billed separately every 12 months as follows:

(i) D0220 — once;

(ii) D0230 — a maximum of five times;

(iii) D0270 — a maximum of twice, or D0272 once;

(E) The Division shall reimburse for panoramic (D0330) or intra-oral complete series (D0210) once every five years, but both cannot be done within the five-year period;

(F) Clients shall be a minimum of six years old for billing intra-oral complete series (D0210). The minimum standards for reimbursement of intra-oral complete series are:

(i) For clients age six through 11- a minimum of ten periapicals and two bitewings for a total of 12 films;

(ii) For clients ages 12 and older - a minimum of ten periapicals and four bitewings for a total of 14 films;

(G) If fees for multiple single radiographs exceed the allowable reimbursement for a full mouth complete series (D0210), the Division shall reimburse for the complete series;

(H) Additional films may be covered if dentally or medically appropriate, e.g., fractures (Refer to OAR 410-123-1060 and 410-120-0000);

(I) If the Division determines the number of radiographs to be excessive, payment for some or all radiographs of the same tooth or area may be denied;

(J) The exception to these limitations is if the client is new to the office or clinic and the office or clinic is unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records shall be included in the client's records;

(K) Digital radiographs, if printed, shall be on photo paper to assure sufficient quality of images.

(4) PREVENTIVE SERVICES:

(a) Prophylaxis:

(A) For children under 19 years of age — Limited to twice per 12 months;

(B) For adults 19 years of age and older — Limited to once per 12 months;

(C) Additional prophylaxis benefit provisions may be available for persons with high risk oral conditions due to disease process, pregnancy, medications, or other medical treatments or conditions, severe periodontal disease, rampant caries and for persons with disabilities who cannot perform adequate daily oral health care;

(D) Are coded using the appropriate Current Dental Terminology (CDT) coding:

(i) D1110 (Prophylaxis — Adult) — Use for clients 14 years of age and older; and

(ii) D1120 (Prophylaxis — Child) — Use for clients under 14 years of age;

(b) Topical fluoride treatment:

(A) For adults 19 years of age and older — Limited to once every 12 months;

(B) For children under 19 years of age — Limited to twice every 12 months;

(C) Additional topical fluoride treatments may be available, up to a total of four treatments per client within a 12-month period, when high-risk conditions or oral health factors are clearly documented in chart notes for clients who:

(i) Have high-risk oral conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;

(ii) Are pregnant;

(iii) Have physical disabilities and cannot perform adequate, daily oral health care;

(iv) Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily oral health care; or

(v) Are under seven years old with high-risk oral health factors, such as poor oral hygiene, deep pits and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc.;

(D) Fluoride limits include any combination of fluoride varnish (D1206) or other topical fluoride (D1208);

(c) Sealants (D1351):

(A) Are covered only for children under 16 years of age;

(B) The Division limits coverage to:

(i) Permanent molars; and

(ii) Only one sealant treatment per molar every five years, except for visible evidence of clinical failure;

(d) Tobacco cessation:

(A) For services provided during a dental visit, bill as a dental service using CDT code D1320 when the following brief counseling is provided:

- (i) Ask patients about their tobacco-use status at each visit and record information in the chart;
- (ii) Advise patients on their oral health conditions related to tobacco use and give direct advice to quit using tobacco and a strong personalized message to seek help; and
- (iii) Refer patients who are ready to quit, utilizing internal and external resources, to complete the remaining three A's (assess, assist, arrange) of the standard intervention protocol for tobacco;

(B) The Division allows a maximum of ten services within a three-month period;

(e) Space management:

(A) The Division shall cover fixed and removable space maintainers (D1510, D1515, D1520, and D1525) only for clients under 19 years of age;

(B) The Division may not reimburse for replacement of lost or damaged removable space maintainers.

(5) RESTORATIVE SERVICES:

(a) Amalgam and resin-based composite restorations, direct:

(A) Resin-based composite crowns on anterior teeth (D2390) are only covered for clients under 21 years of age or who are pregnant;

(B) The Division reimburses posterior composite restorations at the same rate as amalgam restorations;

(C) The Division limits payment for replacement of posterior composite restorations to once every five years;

(D) The Division limits payment of covered restorations to the maximum restoration fee of four surfaces per tooth. Refer to the American Dental Association (ADA) CDT codebook for definitions of restorative procedures;

(E) Providers shall combine and bill multiple surface restorations as one line per tooth using the appropriate code. Providers may not bill multiple surface restorations performed on a single tooth on the same day on separate lines. For example, if tooth #30 has a buccal amalgam and a mesial-occlusal-distal (MOD) amalgam, then bill MOD, B, using code D2161 (four or more surfaces);

(F) The Division may not reimburse for an amalgam or composite restoration and a crown on the same tooth;

(G) Interim therapeutic restoration on primary dentition (D2941) is covered to restore and prevent progression of dental caries. Interim therapeutic restoration is not a definitive restoration.

(H) Reattachment of tooth fragment (D2921) is covered once in the lifetime of a tooth when there is no pulp exposure and no need for endodontic treatment.

(I) The Division reimburses for a surface not more than once in each treatment episode regardless of the number or combination of restorations;

(J) The restoration fee includes payment for occlusal adjustment and polishing of the restoration;

(b) Indirect crowns and related services:

(A) General payment policies:

(i) The fee for the crown includes payment for preparation of the gingival tissue;

(ii) The Division shall cover crowns only when:

(I) There is significant loss of clinical crown and no other restoration will restore function; and

(II) The crown-to-root ratio is 50:50 or better, and the tooth is restorable without other surgical procedures;

(iii) The Division shall cover core buildup (D2950) only when necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture and only when done in conjunction with a crown. Less than 50 percent of the tooth structure must be remaining for coverage of the core buildup.

(iv) Reimbursement of retention pins (D2951) is per tooth, not per pin;

(B) The Division shall not cover the following services:

(i) Endodontic therapy alone (with or without a post);

(ii) Aesthetics (cosmetics);

(iii) Crowns in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason;

(C) The Division shall cover acrylic heat or light cured crowns (D2970 temporary crown, fractured tooth) — allowed only for anterior permanent teeth;

(D) The Division shall cover the following only for clients under 21 years of age or who are pregnant:

(i) Prefabricated plastic crowns (D2932) are allowed only for anterior teeth, permanent or primary;

(ii) Stainless steel crowns (D2930/D2931) are allowed only for anterior primary teeth and posterior permanent or primary teeth;

(iii) Prefabricated stainless steel crowns with resin window (D2933) are allowed only for anterior teeth, permanent or primary;

(iv) Prefabricated post and core in addition to crowns (D2954/D2957);

(v) Permanent crowns (resin-based composite — D2710 and D2712, and porcelain fused to metal (PFM) — D2751 and D2752) as follows:

(I) Limited to teeth numbers 6–11, 22 and 27 only, if dentally appropriate;

(II) Limited to four in a seven-year period. This limitation includes any replacement crowns allowed according to (E)(i) of this rule;

(III) Only for clients at least 16 years of age; and

(IV) Rampant caries are arrested, and the client demonstrates a period of oral hygiene before prosthetics are proposed;

(vi) PFM crowns (D2751 and D2752) shall also meet the following additional criteria:

(I) The dental practitioner has attempted all other dentally appropriate restoration options and documented failure of those options;

(II) Written documentation in the client's chart indicates that PFM is the only restoration option that will restore function;

(III) The dental practitioner submits radiographs to the Division for review; history, diagnosis, and treatment plan may be requested. (See OAR 410-123-1100 Services Reviewed by the Division);

(IV) The client has documented stable periodontal status with pocket depths within 1–3 millimeters. If PFM crowns are placed with pocket depths of 4 millimeters and over, documentation shall be maintained in the client's chart of the dentist's findings supporting stability and why the increased pocket depths will not adversely affect expected long-term prognosis;

(V) The crown has a favorable long-term prognosis; and

(VI) If the tooth to be crowned is a clasp/abutment tooth in partial denture, both prognosis for the crown itself and the tooth's contribution to partial denture shall have favorable expected long-term prognosis;

(E) Crown replacement:

(i) Permanent crown replacement limited to once every seven years;

(ii) All other crown replacement limited to once every five years; and

(iii) The Division may make exceptions to crown replacement limitations due to acute trauma, based on the following factors:

(I) Extent of crown damage;

(II) Extent of damage to other teeth or crowns;

(III) Extent of impaired mastication;

(IV) Tooth is restorable without other surgical procedures; and

(V) If loss of tooth would result in coverage of removable prosthetic;

(F) Crown repair (D2980) is limited to only anterior teeth.

(6) ENDODONTIC SERVICES:

(a) Endodontic therapy:

(A) Pulpal therapy on primary teeth (D3230 and D3240) is covered only for clients under 21 years of age;

(B) For permanent teeth:

(i) Anterior and bicuspid endodontic therapy (D3310 and D3320) is covered for all OHP Plus clients; and

(ii) Molar endodontic therapy (D3330):

(I) For clients through age 20, is covered only for first and second molars; and

(II) For clients age 21 and older who are pregnant, is covered only for first molars;

(C) The Division covers endodontics only if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures;

(b) Endodontic retreatment and apicoectomy:

(A) The Division does not cover retreatment of a previous root canal or apicoectomy for bicuspid or molars;

(B) The Division limits either a retreatment or an apicoectomy (but not both procedures for the same tooth) to symptomatic anterior teeth when:

(i) Crown-to-root ratio is 50:50 or better;

(ii) The tooth is restorable without other surgical procedures; or

(iii) If loss of tooth would result in the need for removable prosthodontics;

(C) Retrograde filling (D3430) is covered only when done in conjunction with a covered apicoectomy of an anterior tooth;

(c) The Division does not allow separate reimbursement for open-and-drain as a palliative procedure when the root canal is completed on the same date of service or if the same practitioner or dental practitioner in the same group practice completed the procedure;

(d) The Division covers endodontics if the tooth is restorable within the OHP benefit coverage package;

(e) Apexification/recalcification procedures:

(A) The Division limits payment for apexification to a maximum of five treatments on permanent teeth only;

(B) Apexification/recalcification procedures are covered only for clients under 21 years of age or who are pregnant.

(7) PERIODONTIC SERVICES:

(a) Surgical periodontal services:

(A) Gingivectomy/Gingivoplasty (D4210 and D4211) — limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g., Dilantin hyperplasia; and

(B) Includes six months routine postoperative care;

(C) The Division shall consider gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212) as part of the restoration and will not provide a separate reimbursement for this procedure;

(b) Non-surgical periodontal services:

(A) Periodontal scaling and root planing (D4341 and D4342):

(i) For clients through age 20, allowed once every two years;

(ii) For clients age 21 and over, allowed once every three years;

(iii) A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances;

(iv) Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets 5 mm or greater:

(I) D4341 is allowed for quadrants with at least four or more teeth with pockets 5 mm or greater;

(II) D4342 is allowed for quadrants with at least two teeth with pocket depths of 5 mm or greater;

(v) Prior authorization for more frequent scaling and root planing may be requested when:

(I) Medically/dentally necessary due to periodontal disease as defined above is found during pregnancy; and

(II) Client's medical record is submitted that supports the need for increased scaling and root planing;

(B) Full mouth debridement (D4355):

(i) For clients through age 20, allowed only once every two years;

(ii) For clients age 21 and older, allowed once every three years;

(c) Periodontal maintenance (D4910):

(A) For clients through age 20, allowed once every six months;

(B) For clients age 21 and older:

(i) Limited to following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years;

(ii) Allowed once every twelve months;

(iii) Prior authorization for more frequent periodontal maintenance may be requested when:

(I) Medically/dentally necessary, such as due to presence of periodontal disease during pregnancy; and

(II) Client's medical record is submitted that supports the need for increased periodontal maintenance (chart notes, pocket depths and radiographs);

(d) Records shall clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and/or radiographs;

(e) The Division may not reimburse for procedures identified by the following codes if performed on the same date of service:

(A) D1110 (Prophylaxis — adult);

(B) D1120 (Prophylaxis — child);

(C) D4210 (Gingivectomy or gingivoplasty — four or more contiguous teeth or bounded teeth spaces per quadrant);

(D) D4211 (Gingivectomy or gingivoplasty — one to three contiguous teeth or bounded teeth spaces per quadrant);

(E) D4341 (Periodontal scaling and root planning — four or more teeth per quadrant);

(F) D4342 (Periodontal scaling and root planning — one to three teeth per quadrant);

(G) D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis); and

(H) D4910 (Periodontal maintenance).

(8) REMOVABLE PROSTHODONTIC SERVICES:

(a) Clients age 16 years and older are eligible for removable resin base partial dentures (D5211-D5212) and full dentures (complete or immediate, D5110-D5140);

(b) The Division limits full dentures for clients age 21 and older to only those clients who are recently edentulous:

(A) For the purposes of this rule:

(i) "Edentulous" means all teeth removed from the jaw for which the denture is being provided; and

(ii) "Recently edentulous" means the most recent extractions from that jaw occurred within six months of the delivery of the final denture (or, for fabricated prosthetics, the final impression) for that jaw;

(B) See OAR 410-123-1000 for detail regarding billing fabricated prosthetics;

(c) The fee for the partial and full dentures includes payment for adjustments during the six-month period following delivery to clients;

(d) Resin partial dentures (D5211-D5212):

(A) The Division may not approve resin partial dentures if stainless steel crowns are used as abutments;

(B) For clients through age 20, the client shall have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;

(C) For clients age 21 and older, the client shall have one or more missing anterior teeth or six or more missing posterior teeth per arch with documentation by the provider of resulting space causing serious impairment to mastication. Third molars are not a consideration when counting missing teeth;

(D) The dental practitioner shall note the teeth to be replaced and teeth to be clasped when requesting prior authorization (PA);

(e) Replacement of removable partial or full dentures, when it cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement), is limited to the following:

(A) For clients at least 16 years and under 21 years of age, the Division shall replace full or partial dentures once every ten years, only if dentally appropriate. This does not imply that replacement of dentures or partials shall be done once every ten years, but only when dentally appropriate;

(B) For clients 21 years of age and older, the Division may not cover replacement of full dentures but shall cover replacement of partial dentures once every ten (10) years only if dentally appropriate;

(C) The ten year limitations apply to the client regardless of the client's OHP or Dental Care Organization (DCO)/Coordinated Care Organization (CCO) enrollment status at the time the client's last denture or partial was received. For example: A client receives a partial on February 1, 2002, and becomes a FFS OHP client in 2005. The client is not eligible for a replacement partial until February 1, 2012. The client gets a replacement partial on February 3, 2012 while FFS and a year later enrolls in a DCO or CCO. The client would not be eligible for another partial until February 3, 2022, regardless of DCO, CCO, or FFS enrollment;

(D) Replacement of partial dentures with full dentures is payable ten years after the partial denture placement. Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant replacement;

(f) The Division limits reimbursement of adjustments and repairs of dentures that are needed beyond six months after delivery of the denture as follows for clients 21 years of age and older:

(A) A maximum of four times per year for:

(i) Adjusting complete and partial dentures, per arch (D5410-D5422);

(ii) Replacing missing or broken teeth on a complete denture, each tooth (D5520);

(iii) Replacing broken tooth on a partial denture, each tooth (D5640);

(iv) Adding tooth to existing partial denture (D5650);

(B) A maximum of two times per year for:

(i) Repairing broken complete denture base (D5510);

(ii) Repairing partial resin denture base (D5610);

- (iii) Repairing partial cast framework (D5620);
- (iv) Repairing or replacing broken clasp (D5630);
- (v) Adding clasp to existing partial denture (D5660);
- (g) Replacement of all teeth and acrylic on cast metal framework (D5670, D5671):
 - (A) Is covered for clients age 16 and older a maximum of once every ten (10) years, per arch;
 - (B) Ten years or more shall have passed since the original partial denture was delivered;
 - (C) Is considered replacement of the partial so a new partial denture may not be reimbursed for another ten years; and
 - (D) Requires prior authorization as it is considered a replacement partial denture;
- (h) Denture rebase procedures:
 - (A) The Division shall cover rebases only if a reline may not adequately solve the problem;
 - (B) For clients through age 20, the Division limits payment for rebase to once every three years;
 - (C) For clients age 21 and older:
 - (i) There shall be documentation of a current reline that has been done and failed; and
 - (ii) The Division limits payment for rebase to once every five years;
 - (D) The Division may make exceptions to this limitation in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant rebasing;
- (i) Denture reline procedures:
 - (A) For clients through age 20, the Division limits payment for reline of complete or partial dentures to once every three years;
 - (B) For clients age 21 and older, the Division limits payment for reline of complete or partial dentures to once every five years;
 - (C) The Division may make exceptions to this limitation under the same conditions warranting replacement;
 - (D) Laboratory relines:
 - (i) Are not payable prior to six months after placement of an immediate denture; and
 - (ii) For clients through age 20, are limited to once every three years;
 - (iii) For clients age 21 and older, are limited to once every five years;
- (j) Interim partial dentures (D5820-D5821, also referred to as "flippers"):

(A) Are allowed if the client has one or more anterior teeth missing; and

(B) The Division shall reimburse for replacement of interim partial dentures once every five years but only when dentally appropriate;

(k) Tissue conditioning:

(A) Is allowed once per denture unit in conjunction with immediate dentures; and

(B) Is allowed once prior to new prosthetic placement.

(9) MAXILLOFACIAL PROSTHETIC SERVICES:

(a) Fluoride gel carrier (D5986) is limited to those patients whose severity of oral disease causes the increased cleaning and fluoride treatments allowed in rule to be insufficient. The dental practitioner shall document failure of those options prior to use of the fluoride gel carrier;

(b) All other maxillofacial prosthetics (D5900-D5999) are medical services. Refer to the "Covered and Non-Covered Dental Services" document and OAR 410-123-1220:

(A) Bill for medical maxillofacial prosthetics using the professional (CMS1500, DMAP 505 or 837P) claim format:

(B) For clients receiving services through a CCO or PHP, bill medical maxillofacial prosthetics to the CCO or PHP;

(C) For clients receiving medical services through FFS, bill the Division.

(10) ORAL SURGERY SERVICES:

(a) Bill the following procedures in an accepted dental claim format using CDT codes:

(A) Procedures that are directly related to the teeth and supporting structures that are not due to a medical condition or diagnosis, including such procedures performed in an ambulatory surgical center (ASC) or an inpatient or outpatient hospital setting;

(B) Services performed in a dental office setting or an oral surgeon's office:

(i) Such services include, but are not limited to, all dental procedures, local anesthesia, surgical postoperative care, radiographs, and follow-up visits;

(ii) Refer to OAR 410-123-1160 for any PA requirements for specific procedures;

(b) Bill the following procedures using the professional claim format and the appropriate American Medical Association (AMA) CPT procedure and ICD910 diagnosis codes:

(A) Procedures that are a result of a medical condition (i.e., fractures, cancer);

(B) Services requiring hospital dentistry that are the result of a medical condition/diagnosis (i.e., fracture, cancer);

(c) Refer to the "Covered and Non-Covered Dental Services" document to see a list of CDT procedure codes on the Prioritized List that may also have CPT medical codes. See OAR 410-123-1220. The procedures listed as "medical" on the table may be covered as medical procedures, and the table may not be all-inclusive of every dental code that has a corresponding medical code;

(d) For clients enrolled in a DCO or CCO responsible for dental services, the DCO or CCO shall pay for those services in the dental plan package;

(e) Oral surgical services performed in an ASC or an inpatient or outpatient hospital setting:

(A) Require PA;

(B) For clients enrolled in a CCO or FCHP, the CCO or FCHP shall pay for the facility charge and anesthesia services. For clients enrolled in a Physician Care Organization (PCO), the PCO shall pay for the outpatient facility charge (including ASCs) and anesthesia. Refer to the current Medical Surgical Services administrative rules in OAR chapter 410, division 130 for more information;

(C) If a client is enrolled in a CCO or PHP, the provider shall contact the CCO or PHP for any required authorization before the service is rendered;

(f) All codes listed as “by report” require an operative report;

(g) The Division covers payment for tooth re-implantation only in cases of traumatic avulsion where there are good indications of success;

(h) Biopsies collected are reimbursed as a dental service. Laboratory services of biopsies are reimbursed as a medical service;

(i) The Division does not cover surgical excisions of soft tissue lesions (D7410-D7415);

(j) Extractions — Includes local anesthesia and routine postoperative care, including treatment of a dry socket if done by the provider of the extraction. Dry socket is not considered a separate service;

(k) Surgical extractions:

(A) Include local anesthesia and routine post-operative care;

(B) The Division limits payment for surgical removal of impacted teeth or removal of residual tooth roots to treatment for only those teeth that have acute infection or abscess, severe tooth pain, and unusual swelling of the face or gums;

(C) The Division does not cover alveoplasty in conjunction with extractions (D7310 and D7311) separately from the extraction;

(D) The Division covers alveoplasty not in conjunction with extractions (D7320-D7321) only for clients under 21 years of age or who are pregnant;

(l) Frenulectomy/frenulotomy (D7960) and frenuloplasty (D7963):

(A) The Division covers either frenulectomy or frenuloplasty once per lifetime per arch only for clients under age 21;

(B) The Division covers maxillary labial frenulectomy only for clients age 12 through 20;

(C) The Division shall cover frenulectomy/frenuloplasty in the following situations:

(i) When the client has ankyloglossia;

(ii) When the condition is deemed to cause gingival recession; or

(iii) When the condition is deemed to cause movement of the gingival margin when the frenum is placed under tension;

(m) The Division covers excision of pericoronal gingival (D7971) only for clients under age 21 or who are pregnant.

(11) ORTHODONTIA SERVICES:

(a) The Division limits orthodontia services and extractions to eligible clients:

(A) With the ICD-10-CM diagnosis of:

(i) Cleft palate; or

(ii) Cleft palate with cleft lip; and

(B) Whose orthodontia treatment began prior to 21 years of age; or

(C) Whose surgical corrections of cleft palate or cleft lip were not completed prior to age 21;

(b) PA is required for orthodontia exams and records. A referral letter from a physician or dentist indicating diagnosis of cleft palate or cleft lip shall be included in the client's record and a copy sent with the PA request;

(c) Documentation in the client's record shall include diagnosis, length, and type of treatment;

(d) Payment for appliance therapy includes the appliance and all follow-up visits;

(e) Orthodontists evaluate orthodontia treatment for cleft palate/cleft lip as two phases. Stage one is generally the use of an activator (palatal expander), and stage two is generally the placement of fixed appliances (banding). The Division shall reimburse each phase separately;

(f) The Division shall pay for orthodontia in one lump sum at the beginning of each phase of treatment. Payment for each phase is for all orthodontia-related services. If the client transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist shall refund to the Division any unused amount of payment after applying the following formula: Total payment minus \$300.00 (for banding) multiplied by the percentage of treatment remaining;

(g) The Division shall use the length of the treatment plan from the original request for authorization to determine the number of treatment months remaining;

(h) As long as the orthodontist continues treatment, the Division may not require a refund even though the client may become ineligible for medical assistance sometime during the treatment period;

(i) Code:

(A) D8660 — PA required (reimbursement for required orthodontia records is included);

(B) Codes D8010-D8690 — PA required.

(12) ADJUNCTIVE GENERAL AND OTHER SERVICES:

(a) Fixed partial denture sectioning (D9120) is covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly treatment;

(b) Anesthesia:

(A) Only use general anesthesia or IV sedation for those clients with concurrent needs: age; physical, medical or mental status; or degree of difficulty of the procedure (D9220, D9221, D9241 and D9242);

(B) The Division reimburses providers for general anesthesia or IV sedation as follows:

(i) D9220 or D9241: For the first 30 minutes;

(ii) D9221 or D9242: For each additional 15-minute period, up to three hours on the same day of service. Each 15-minute period represents a quantity of one. Enter this number in the quantity column;

(C) The Division reimburses administration of Nitrous Oxide (D9230) per date of service, not by time;

(D) Oral pre-medication anesthesia for conscious sedation (D9248):

(i) Limited to clients under 13 years of age;

(ii) Limited to four times per year;

(iii) Includes payment for monitoring and Nitrous Oxide; and

(iv) Requires use of multiple agents to receive payment;

(E) Upon request, providers shall submit a copy of their permit to administer anesthesia, analgesia, and sedation to the Division;

(F) For the purpose of Title XIX and Title XXI, the Division limits payment for code D9630 to those oral medications used during a procedure and is not intended for "take home" medication;

(c) The Division limits reimbursement of house/extended care facility call (D9410) only for urgent or emergent dental visits that occur outside of a dental office. This code is not reimbursable for provision of preventive services or for services provided outside of the office for the provider or facilities' convenience;

(d) Oral devices/appliances (E0485, E0486):

(A) These may be placed or fabricated by a dentist or oral surgeon but are considered a medical service;

(B) Bill the Division, CCO, or the PHP for these codes using the professional claim format.

Stat. Auth.: ORS 413.042, 414.065 & 414.707

Stats. Implemented: ORS 414.065 & 414.707

410-123-1620

Procedure and Diagnosis Codes

(1) The Division requires providers to use the standardized code sets adopted by the Health Insurance Portability and Accountability Act (HIPAA) and the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards in effect for the date the service(s) was provided.

(2) Procedure codes:

(a) For dental services, use Current Dental Terminology (CDT) codes as maintained and distributed by the American Dental Association. Contact the American Dental Association (ADA) to obtain a current copy of the CDT reference manual. Current Dental Terminology (including procedure codes, definitions (descriptors) and other data) is copyrighted by the ADA. © 2012 American Dental Association. All rights reserved. Applicable Federal Acquisition Regulation Clauses/Department of Defense Federal Acquisition Regulation Supplement (FARS/DFARS) apply;

(b) For physician services and other health care services, use Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes.

(3) Diagnosis codes:

(a) International Classification of Diseases 109th Clinical Modification (ICD-109-CM) diagnosis codes are not required for dental services submitted on an ADA claim form;

(b) When Oregon Administrative Rule (OAR) 410-123-1260 requires services to be billed on a professional claim form, ICD-109-CM diagnosis codes are required. Refer to the Medical-Surgical administrative rules for additional information, OAR 410 division 130.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

DIVISION 124 TRANSPLANT SERVICES

410-124-0000

Transplant Services

- (1) The Division of Medical Assistance Programs (Division) will make payment for prior authorized and emergency transplant services identified in these rules as covered for eligible clients receiving the Basic Benefit Health Care Package and when the Division transplant criteria described in OAR 410-124-0010 and 410-124-0060 through 410-124-0160 is met. All other Benefit Packages do not cover transplant.
- (2) The Division will only prior authorize and reimburse for transplants if:
 - (a) All Division criteria are met; and
 - (b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and
 - (c) The ~~ICD-9~~ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.
- (3) Simultaneous multiple organ transplants are covered only if specifically identified as paired on the same currently funded line on the Oregon Health Plan (OHP) Prioritized List of Health Services whether the transplants are for the same underlying disease or for unrelated, but concomitant, underlying diseases.
- (4) Not Covered Transplant Services: The following types of transplants are not covered by the Division:
 - (a) Transplants which are considered experimental or investigational or which are performed on an experimental or investigational basis, as determined by the Division;
 - (b) Transplant services which are contraindicated, as described in OAR 410-124-0060 through 410-124-0160;
 - (c) Transplants which have not been prior authorized for payment by the Division or the client's managed health care plan;
 - (d) Transplants which do not meet the guidelines for an emergency transplant in OAR 410-124-0040;
 - (e) Transplants which are not described as covered in OAR 410-141-0480 and 410-141-0520.
- (5) Selection of Transplant Centers: Transplant services will be reimbursed only when provided in a transplant center that provides quality services, demonstrates good patient outcomes and compliance with all Division facility criteria. The transplant center must have provided transplant services for a period of at least two years and must have completed a minimum of 12 cases in the most recent year. The patient-and-graft-survival rates must be equal to or greater than the appropriate standard indicated in this rule. A transplant center which has had at least two years of experience in transplantation of any solid organ (heart, liver, lung, pancreas) and which has met or exceeded the appropriate standards may be considered for

reimbursement for the transplantation of other solid organs and/or autologous or allogeneic bone marrow transplantation:

(a) An experienced and proficient transplant team and a well established transplant support infrastructure at the same physical location as the transplant service is required for transplant services rendered to Division clients. These transplant criteria are crucial to successful transplant outcome. Therefore, consortia will not be approved or contracted with for the provision of transplant services for Division clients. No Division transplant contract, prior approval or reimbursement will be made to consortia for transplant services where, as determined by the Division, there is no assurance that the individual facilities that make up the consortia independently meet Division criteria. The Division's transplant criteria must be met individually by a facility to demonstrate substantial experience with the procedure;

(b) Once a transplant facility has been approved and contracted for Division transplant services, it is obliged to report immediately to the Division any events or changes that would affect its approved status. Specifically, a transplant facility is required to report, within a reasonable period of time, any significant decrease in its experience level or survival rates, the departure of key members of the transplant team or any other major changes that could affect the performance of transplants at the facility. Changes from the terms of approval may lead to prospective withdrawal of approval for Division coverage of transplants performed at the facility;

(c) Fully Capitated Health Plans (FCHPs) that contract with non-Division contracted facilities for Basic Health Care Package clients will develop and use appropriate transplant facility criteria to evaluate and monitor for quality services at the transplant facility;

(d) Transplant centers which have less than two years experience in solid organ transplant may be reimbursed, at the Division's discretion, for allogeneic or autologous bone marrow transplants upon completion of two years of experience in bone marrow transplantation with patient survival rates equal to or exceeding those defined in section (5) of this rule;

(e) The Division will discontinue the contract with a transplant center when the graft and/or survival rates fall below the standards indicated in this rule for a period of two consecutive years.

(6) Standards for Transplant Centers:

(a) Heart, heart-lung and lung transplants:

(A) Heart: One-year patient survival rate of at least 80%;

(B) Heart-Lung: One-year patient survival rate of at least 65%;

(C) Lung: One-year patient survival rate of at least 65%.

(b) Bone Marrow (autologous and allogeneic), peripheral stem cell (autologous and allogeneic) and cord blood (allogeneic) transplants: One-year patient survival rate of at least 50%;

(c) Liver transplants: One year patient survival rate of at least 70% and one year graft survival rate of at least 60%;

(d) Simultaneous pancreas-kidney and pancreas-after-kidney transplants: One year patient survival rate of at least 90% and one year graft survival rate of at least 60%;

(e) Kidney transplants: One year patient survival rate of at least 92% and one year graft survival rate of at least 85%.

(7) Selection of transplant centers by geographic location: If the services are available in the state of Oregon, reimbursement will not be made to out-of-state transplant centers. Out-of-state centers will be considered only if:

(a) The type of transplant required is not available in the state of Oregon and/or the type of transplant (for example, liver transplant) is available in the state of Oregon but the Oregon transplant center does not provide that type of transplant for all clients or all covered diagnoses, (e.g., pediatric transplants); and

(b) An in-state transplant center requests the out-of-state transplant referral; and

(c) An in-state transplant facility recommends transplantation based on in-state facility and Division criteria; or

(d) It would be cost effective as determined by the Division. For example, if the transplant service is covered by the client's benefit package and the client's primary insurer (i.e., Medicare) requires the use of an out-of-state transplant center; or

(e) It is a contiguous, out-of-state transplant center that has a contract or special agreement for reimbursement with the Division.

(8) Professional and other services will be covered according to administrative rules in the applicable provider guides.

(9) Reimbursement for covered transplants and follow-up care for transplant services is as follows:

(a) For transplants for fee-for-service ~~or Primary Care Case Manager (PCCM)~~ clients:

(A) Transplant facility services -- by contract with the Division;

(B) Professional services -- at the Division's maximum allowable rates.

(b) For emergency services, when no special agreement has been established, the rate will be:

(A) 75% of standard inpatient billed charge; and

(B) 50% of standard outpatient billed charge; or

(C) The payment rate set by the Medical Assistance program of the state in which the center is located, whichever is lower.

(c) For clients enrolled in FCHPs, reimbursement for transplant services will be by agreement between the FCHP and the transplant center.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-124-0020

Prior Authorization for All Covered Transplants, Except Cornea and Kidney

(1) Prior authorization is required as follows:

(a) All non-emergency transplant services require prior authorization of payment, except for kidney alone and cornea transplants which require prior authorization only if performed out-of-state;

(b) Pre-transplant evaluations provided by the transplant center require prior authorization. Prior Authorization will only be made for evaluations for covered transplants.

(2) The prior authorization request for all covered transplants is initiated by the client's in-state referring physician or the transplant physician. The initial request should contain all available information outlined in subsection (3) of this rule, below:

(a) For fee-for-service ~~and Primary Care Case Manager (PCCM)~~ clients, the request should be sent to the Division of Medical Assistance Programs (Division);

(b) For clients enrolled in a Fully Capitated Health Plan (FCHP), requests for transplant services should be sent directly to the FCHP.

(3) A completed request for authorization must contain the following information. Failure to submit all the information will delay processing of the request. An optional form is provided at the end of the Transplant Services guide for provider convenience in submitting requests for evaluations only:

(a) The name, age, Medical Assistance Identification number, and birth date of the client;

(b) A description of the medical condition and full ~~ICD-9~~ICD-10-CM coding which necessitates a transplant;

(c) The type of transplant proposed, with CPT code;

(d) The results of a current HIV test, (completed within 6 months of request for transplant authorization);

(e) Any other evidence of contraindications for the type of transplant being considered (see contraindications under each transplant type);

(f) The client's prognosis, with and without a transplant, including estimated life expectancy with and without the transplant;

(g) Transplant treatment alternatives:

(A) A history of other treatments which have been tried;

(B) Treatments that have been considered and ruled out, including discussion of why they have been ruled out.

(h) An evaluation based upon a comprehensive examination completed by a board certified specialist in a field directly related to the condition of the client which necessitates the transplant;

(i) If already done before requesting prior authorization, the results of any medical and/or social evaluation completed by a transplant center should be included in the prior authorization request. The completion of an evaluation by a transplant center before receiving prior authorization from the Division does not obligate the Division to reimburse that transplant center for the evaluation or for any other transplant services not prior authorized.

(4) Prior authorization approval process and requirements:

(a) For clients receiving services on a fee-for-service basis ~~and/or enrolled with a PCCM~~:

(A) After receiving a completed request, the Division will notify the referring physician within two weeks if an evaluation at a transplant center is approved or denied;

(B) A final determination for the actual transplant requires an evaluation by a selected transplant center, which will include:

(i) A medical evaluation;

(ii) An estimate of the client's motivation and ability, both physical and psychological, to adhere to the post-transplant regimen;

(iii) The transplant center's assessment of the probability of a successful outcome, based on the type of transplant requested, the condition of the client, and the client's ability to adhere to the post-transplant regimen; and

(iv) A recommendation using both the transplant center's own criteria, and the Division criteria.

(b) For Oregon Health Plan (OHP) transplant eligible clients who are in an FCHP: Refer to the FCHP for approval process and requirements;

(c) The prior authorization request will be approved if:

(A) All Division criteria are met; and

(B) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(C) The ~~ICD-9~~CD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services.

(5) The referring physician, transplant center, and the client will be notified in writing by the Division or the FCHP of the prior authorization decision.

(6) Prior authorization of a transplant does not guarantee reimbursement for the services of any provider if, at the time the transplant is performed, intercurrent events have caused the individual's medical condition to deteriorate to the point at which survival with or without transplant for a period of more than sixty days is unlikely.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-124-0060

Criteria and Contraindications for Heart Transplants

(1) Prior authorization for a heart transplant will only be approved for a client in whom irreversible heart disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) A client considered for a heart transplant must have a poor prognosis, i.e., less than a 50% chance of survival for 18 months without a transplant as a result of poor cardiac functional status or cardio/pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of heart transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early congenital heart disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for heart transplant services:

- (a) Untreatable systemic vasculitis;
- (b) Incurable malignancy;
- (c) Diabetes with end-organ damage;
- (d) Active infection which will interfere with the client's recovery;
- (e) Refractory bone marrow insufficiency;
- (f) Irreversible renal disease;
- (g) Irreversible hepatic disease;
- (h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

- (a) Hyperlipoproteinemia;
- (b) Curable malignancy;
- (c) Significant cerebrovascular or peripheral vascular disease;
- (d) Unresolved or continuing thromboembolic disease or pulmonary infarction;
- (e) Irreversible pulmonary hypertension;
- (f) Serious psychological disorders;
- (g) Drug or alcohol abuse.

(7) The Division of Medical Assistance Programs (Division) will only prior authorize and reimburse for heart transplants if:

- (a) All Division criteria are met; and
- (b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ~~ICD-9~~ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-124-0063

Criteria and Contraindications for Heart-Lung Transplants

(1) Prior authorization for a heart-lung transplant will only be approved for a client in whom irreversible cardio-pulmonary disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) A client considered for a heart-lung transplant must have cardio-pulmonary failure with a poor prognosis, i.e., less than a 50% chance of survival for 18 months without a transplant as a result of poor cardiac functional status or cardio/pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of heart-lung transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early cardio-pulmonary disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for heart-lung transplant services:

- (a) Untreatable systemic vasculitis;
- (b) Incurable malignancy;
- (c) Diabetes with end-organ damage;
- (d) Active infection which will interfere with the client's recovery;
- (e) Refractory bone marrow insufficiency;
- (f) Irreversible renal disease;
- (g) Irreversible hepatic disease;
- (h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

- (a) Hyperlipoproteinemia;
- (b) Curable malignancy;
- (c) Significant cerebrovascular or peripheral vascular disease;

- (d) Unresolved or continuing thromboembolic disease or pulmonary infarction;
- (e) Serious psychological disorders;
- (f) Drug or alcohol abuse.

(7) The Division of Medical Assistance Programs (Division) will only prior authorize and reimburse for heart-lung transplants if:

- (a) All Division criteria are met; and
- (b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and
- (c) The ~~ICD-9~~ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-124-0065

Criteria and Contraindications for Single Lung Transplants

- (1) Prior authorization for a single lung transplant will only be approved for a client in whom irreversible lung disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.
- (2) The client must have a poor prognosis, i.e., less than a 50% chance of survival for 18 months without a transplant as a result of poor pulmonary functional status.
- (3) All alternative medically accepted treatments that have a one year survival rate comparable to that of single lung transplantation must have been tried or considered.
- (4) Requests for transplant services for children suffering from early pulmonary disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.
- (5) A client with one or more of the following contraindications is ineligible for single lung transplant services:
 - (a) Untreatable systemic vasculitis;
 - (b) Incurable malignancy;
 - (c) Diabetes with end-organ damage;
 - (d) Active infection which will interfere with the client's recovery;
 - (e) Refractory bone marrow insufficiency;
 - (f) Irreversible renal disease;

(g) Irreversible hepatic disease;

(h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

(a) Hyperlipoproteinemia;

(b) Curable malignancy;

(c) Significant cerebrovascular or peripheral vascular disease;

(d) Unresolved continuing thromboembolic disease or pulmonary infarction;

(e) Serious psychological disorders;

(f) Drug or alcohol abuse.

(7) The Division of Medical Assistance Programs (Division) will only prior authorize and reimburse for single lung transplants if:

(a) All Division criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ~~ICD-9~~ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-124-0070

Criteria and Contraindications for Bilateral Lung Transplants

(1) Prior authorization for a bilateral lung transplant will only be approved for a client in whom irreversible lung disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) The client must have a poor prognosis, i.e., less than a 50% chance of survival for 18 months without a transplant as a result of poor pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of bilateral lung transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early pulmonary disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for bilateral lung transplant services:

- (a) Untreatable systemic vasculitis;
- (b) Incurable malignancy;
- (c) Diabetes with end-organ damage;
- (d) Active infection which will interfere with the client's recovery;
- (e) Refractory bone marrow insufficiency;
- (f) Irreversible renal disease;
- (g) Irreversible hepatic disease;
- (h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

- (a) Hyperlipoproteinemia;
- (b) Curable malignancy;
- (c) Significant cerebrovascular or peripheral vascular disease;
- (d) Unresolved continuing thromboembolic disease or pulmonary infarction;
- (e) Serious psychological disorders;
- (f) Drug or alcohol abuse.

(7) the Division of Medical Assistance Programs (Division) will only prior authorize and reimburse for bilateral lung transplants if:

- (a) All Division criteria are met; and
- (b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and
- (c) The ~~ICD-9~~ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-124-0080

Criteria and Contraindications for Autologous and Allogeneic Bone Marrow, Autologous and Allogeneic Peripheral Stem Cell and Allogeneic Cord Blood Transplants

(1) The following criteria will be used to evaluate the prior authorization request for all bone marrow and peripheral stem cell transplants:

(a) Transplantation must be the most effective medical treatment, when compared to other alternatives, in prolonging life expectancy to a reasonable degree;

(b) The client must have a maximum probability of a successful clinical outcome and the expectation of not less than a 20 percent five (5) year survival rate, subsequent to the transplant, as supported by medical literature considering each of the following factors:

(A) The type of transplant, i.e., autologous or allogeneic;

(B) The specific diagnosis of the individual;

(C) The stage of illness, i.e., in remission, not in remission, in second remission;

(D) Satisfactory antigen match between donor and recipient in allogeneic transplants;

(c) All alternative treatments with a one year survival rate comparable to that of bone marrow transplantation must have been tried or considered.

(2) Allogeneic transplants will be approved for payment only when there is a minimum of 5-out-of-6 antigen match for bone marrow and peripheral stem cell transplants, or 4-out-of-6 match for cord blood transplants, considering the HLA-A, B, and DR loci. Donor search costs up to an amount of \$15,000 will be covered only if prior authorized.

(3) Donor leukocyte infusions are covered only when:

(a) An early failure or relapse post allogeneic bone marrow transplant occurs; and

(b) Peripheral stem cells are from the original donor.

(4) The following are contraindications for autologous and allogeneic bone marrow, autologous and allogeneic peripheral stem cell and allogeneic cord blood transplants:

(a) Irreversible terminal state (moribund or on life support);

(b) An irreversible disease of any other major organ system likely to limit life expectancy to five (5) years or less;

(c) Positive HIV test results;

(d) Positive pregnancy test.

(5) The following may be considered contraindications to the extent the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:

(a) Serious psychological disorders;

(b) Alcohol or drug abuse.

(6) The Division of Medical Assistance Programs (Division) will prior authorize and reimburse for autologous and allogeneic bone marrow, autologous and allogeneic peripheral stem cell and allogeneic cord blood transplants only if:

(a) All Division criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ~~ICD-9~~ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

(7) The Division will prior authorize and reimburse for autologous and allogeneic bone marrow, autologous and allogeneic peripheral stem cell and allogeneic cord blood transplants for pediatric solid malignancies only if:

(a) Requirements of 410-124-0080(6)(a), (b) and (c) are met; and

(b) There is documentation of a morphology code listed on the currently funded line for pediatric solid tumor in the Prioritized List of Health Services adopted under OAR 410-141-0520.

(8) Prior authorization for harvesting of autologous bone marrow or peripheral stem cells does not guarantee reimbursement for the transplant; the patient must meet the criteria specified above and in 410-124-0020 at the time the transplant is performed.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-124-0090

Criteria and Contraindications for Harvesting Autologous Bone Marrow and Peripheral Stem Cells

(1) The following are contraindications for the harvesting and storage of autologous bone marrow or peripheral stem cells for a potential transplant. The potential transplant recipient has:

(a) Irreversible terminal state (moribund or on life support);

(b) An irreversible disease of any other major organ system likely to limit life expectancy to five (5) years or less;

(c) Positive HIV test results;

(d) Positive pregnancy test.

(2) The following may be considered contraindications for the harvesting and storage of autologous bone marrow or peripheral stem cells for a transplant to the extent the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process. The potential transplant recipient has:

(a) Serious psychological disorders;

(b) Alcohol or drug abuse.

(3) The Division of Medical Assistance Programs (Division) will prior authorize and reimburse for the harvesting and storage of autologous bone marrow or autologous peripheral stem cells for a potential transplant recipient only if:

- (a) All Division criteria are met; and
 - (b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and
 - (c) The ~~ICD-9~~ICD-10-CM diagnosis code(s) and the CPT bone marrow or peripheral stem cell harvesting for transplantation procedure code(s) are paired on a currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520; and
 - (d) There is documentation of a morphology code listed on the currently funded line for pediatric solid tumor in the Prioritized List of Health Services adopted under OAR 410-141-0520; and
 - (e) The client's marrow meets the clinical standards of remission at the time of storage; and
 - (f) A board certified hematologist/oncologist with specific experience in bone marrow transplant (BMT) services (i.e., cryopreservation and immunosuppressive treatment) has recommended the storage of autologous bone marrow or peripheral stem cell collection for possible future transplant/reinfusion; and
 - (g) The client has no contraindications for the harvesting and storage of autologous bone marrow or peripheral stem cells; and
 - (h) The client has no contraindications for bone marrow transplant or peripheral stem cell transplant.
- (4) Prior authorization for harvesting of autologous bone marrow or peripheral stem cells does not guarantee reimbursement for the transplant. The client must meet the criteria specified in this rule and OAR 410-124-0080, and the transplant must be prior authorized by the Division before reimbursement will be approved.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-124-0100

Criteria and Contraindications for Liver and Liver-Kidney Transplants

- (1) Prior authorization for liver or liver-kidney transplants will be approved only for a client in whom irreversible, progressive liver disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.
- (2) Liver-kidney transplant is covered only for a medically documented diagnosis of Caroli's disease (~~ICD-9~~ICD-10-CM 751.62Q44.6).
- (3) The following are contraindications for liver or liver-kidney transplants:
 - (a) Incurable and untreatable malignancy outside the hepatobiliary system;
 - (b) Terminal state due to diseases other than liver disease;
 - (c) Uncontrolled sepsis, or active systemic infection;
 - (d) HIV positive test results;

- (e) Active alcoholism or active substance abuse;
- (f) Alternative effective medical or surgical therapy;
- (g) Presence of uncorrectable significant organ system failure other than liver (excluding short-bowel syndrome or congenital intractable diarrhea).

(4) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:

- (a) Crigler-Najjar Syndrome Type II;
- (b) Amyloidosis;
- (c) Other major system diseases affecting brain, lung, heart, or renal systems;
- (d) Major, not correctable congenital anomalies;
- (e) Serious psychological disorders.

(5) The transplant center will review for current risk of alcohol or other substance abuse and risk of recidivism and will inform the Division of Medical Assistance Programs (Division) of its findings prior to the provision of the transplant.

(6) The Division will only prior authorize and reimburse for liver and liver-kidney transplants if:

- (a) All Division criteria are met; and
- (b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and
- (c) The ~~ICD-9~~ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-124-0105

Criteria and Contraindications for Intestine and Intestine-Liver Transplants

(1) Prior authorization for intestine and intestine-liver transplants will be approved only for:

- (a) A client who has failed Total Parenteral Nutrition (TPN) or who has developed life-threatening complications from TPN;
- (b) A client in whom irreversible, progressive intestine and/or liver disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate subsequent to the transplant, is at least twenty (20) percent as supported by the medical literature.

(2) Intestine and Intestine-Liver transplant is covered only for a medically documented diagnosis of Short Bowel Syndrome and for patients age 5 years or under with diagnosis of

~~ICD-9~~~~ICD-10~~-CM K557.0-K55.9, ~~ICD-9~~~~ICD-10~~-CM 579.3K91.2, or ~~ICD-9~~~~ICD-10~~-CM 777.5P77.9.

(3) Small intestine transplant using a living related donor is considered investigational and will not be covered by The Division of Medical Assistance Programs (Division).

(4) The following are contraindications for intestine or intestine-liver transplants:

(a) Incurable and untreatable malignancy outside the hepatobiliary system;

(b) Terminal state due to diseases other than liver or intestinal disease;

(c) Uncontrolled sepsis, or active systemic infection;

(d) HIV positive test results;

(e) Alternative effective medical or surgical therapy;

(f) Presence of uncorrectable significant organ system failure other than liver or Short-Bowel Syndrome.

(5) The following may be considered contraindications to the extent that the evaluating transplant center and/or specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:

(a) Crigler-Najjar Syndrome Type II;

(b) Amyloidosis;

(c) Other major system diseases affecting brain, lung, heart, or renal systems;

(d) Major, non-correctable congenital anomalies;

(e) Serious psychological disorders.

(6) The Division will prior authorize and reimburse for intestine and intestine-liver transplant if:

(a) All Division criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ~~ICD-9~~~~ICD-10~~-CM diagnosis code(s) and CPT procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-124-0120

Criteria and Contraindications for Simultaneous Pancreas-Kidney and Pancreas After Kidney Transplants

(1) Prior authorization for a Simultaneous Pancreas-Kidney (SPK) or Pancreas after Kidney (PAK) transplant will be approved only for a client in whom irreversible kidney and/or pancreatic disease has advanced to the point where conventional therapy offers no prospect

for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) Simultaneous pancreas-kidney (SPK) transplant is covered only for Type I diabetes mellitus with end stage renal disease (~~ICD-9~~ICD-10-CM codes ~~250.41 or 250.43~~E10.21, E10.22, E10.29, E10.21, E10.65).

(3) Pancreas after kidney (PAK) transplantation will be considered for clients suffering from insulin dependent Type I diabetes after prior successful renal transplant. Pancreas after kidney (PAK) transplant is covered only for Type I diabetes mellitus (~~ICD-9~~ICD-10-CM codes E10.8- E10.11, E10.31, E10.36, E10.39-E10.40-E10.41, E10.44, E10.49, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.349, E10.351, E10.359, E10.610, E10.618, E10.620- E10.622, E10.628, E10.630, E10.638-E10.649, E10.69, T86.10-T86.13, T86.19, T86.890- T86.92, T86.898-T86.99

~~250.01, 250.03, 250.11, 250.13, 250.21, 250.23, 250.31, 250.33, 250.51, 250.53, 250.61, 250.63, 250.81, 250.83, 250.91, 250.93, 996.81 or 996.86~~ with a secondary diagnosis V42.0.

(4) The following are contraindications to SPK and PAK transplants:

(a) Uncorrectable severe coronary artery disease;

(b) Major irreversible disease of any other major organ system likely to limit life expectancy to five years or less;

(c) HIV positive test results.

(5) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:

(a) Serious psychological disorders;

(b) Drug abuse or alcohol abuse.

(6) The Division of Medical Assistance Programs (Division) will only prior authorize and reimburse for Simultaneous Pancreas-Kidney (SPK) or Pancreas after Kidney (PAK) transplants if:

(a) All Division criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ~~ICD-9~~ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

DIVISION 125 HOSPITAL SERVICES

410-125-0045

Coverage and Limitations

In general, most medically appropriate services are covered. There are, however, some restrictions and limitations. Please refer to the Division of Medical Assistance Programs' (Division) General Rules Program for information on general scope of coverage and limitations. Some of the limitations and restrictions that apply to hospital services are:

(1) Prior authorization (PA): Some services require PA for the Plus Benefit Package check OAR 410-125-0080.

(2) Non-Covered services:

(a) Services that are not medically appropriate, unproven medical efficacy or services that are the responsibility of another Department of Human Services (Department) Division are not covered by the Division of Medical Assistance Programs;

(b) Service coverage is based on the Health Services Commission's Prioritized List of Services and the benefit package;

(c) See the General Rules Program (chapter 410, division 120) and other program divisions in chapter 410 for a list of not covered services. Further information on covered and non-covered services is found in the Revenue Code section in the Hospital Services Supplemental Information.

(3) Limitations on hospital benefit days: Clients have no hospital benefit day limitations for treatment of covered services.

(4) Dental services: Clients have dental/denturist services identified as covered on the Health Services Commission Prioritized List (OAR 410-141-520).

(5) Services provided outside of the hospital's licensed facilities; for example, in the client's home or in a nursing home, are not covered by Division as hospital services. The only exceptions to this are Maternity Case Management services and specific nursing or physician services provided during a ground or air ambulance transport.

(6) Dialysis services require a written physician prescription. The prescription must indicate the ~~ICD-9~~ICD-10 diagnosis code and must be retained by the provider of dialysis services for the period of time specified in the General Rules Program.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0141

DRG Rate Methodology

(1) Diagnosis Related Groups:

(a) Diagnosis Related Groups (DRG) is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 910th Revision, Clinical Modification (~~ICD-9~~ICD-10-CM);

(b) The DRG classification methodology assigns a DRG category to each inpatient service, based on the patient's diagnoses, age, procedures performed, length of stay, and discharge status.

(2) Medicare Grouper: The Medicare Grouper is the software used to assign an individual claim to a DRG category. Medicare revises the Grouper program each year in October. The Division of Medical Assistance Programs (Division) uses the Medicare Grouper program in the assignment of inpatient hospital claims. The most recent version of the Medicare grouper will be installed each year within 90 days of the date it is implemented by Medicare. Where better assignment of claims is achieved through changes to the grouper logic, the Division may modify the logic of the grouper program. The Division will work with representatives of hospitals that may be affected by grouper logic changes in reaching a cooperative decision regarding changes. The Division DRG weight tables can be found on the Division web site.

(3) DRG Relative Weights:

(a) Relative weights are a measure of the relative resources required in the treatment of the average case falling within a specific DRG category;

(b) For most DRGs, the Division establishes a relative weight based on federal Medicare DRG weights. For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs, Oregon Title XIX fee-for-service claims history is used. To determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRG, the Division uses the following methodology: Using the formula $N = \frac{Z \cdot S}{R}$ where $Z = 1.15$ (a 75% confidence level), S is the standard deviation, and $R = 10\%$ of the mean. The Division determines the minimum number of claims required to set a stable weight for each DRG (N must be at least 5). For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs lacking sufficient volume, the Division sets a relative weight using:

(A) Division non-Title XIX claims data; or

(B) Data from other sources expected to reflect a population similar to the Division Title XIX caseload;

(c) When a test shows at the 90% confidence level that an externally derived weight is not representative of the average cost of services provided to the Division Title XIX population in that DRG, the weight derived from the Division Title XIX claims history is used instead of the externally derived weight for that DRG;

(d) Those relative weights based on Federal Medicare DRG weights, will be established when changes are made to the DRG Grouper logic. State specific relative weights shall be adjusted, as needed, as determined by the Division. When relative weights are recalculated, the overall Case Mix Index (CMI) will be kept constant. Reweighting of DRGs or the addition or

modification of the grouper logic will not result in a reduction of overall payments or total relative weights.

(4) Case Mix Index: The hospital-specific case mix index is the total of all relative weights for all services provided by a hospital during a period, divided by the number of discharges.

(5) Unit Value: Hospitals larger than fifty (50) beds are reimbursed using the Diagnosis Related Grouper (DRG) as described in (2). Effective for services on or after:

(a) August 15, 2005, the operating unit payment is 100% of 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge.

(b) May 1, 2009, the operating unit payment is 108.5% of the 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge.

(c) Effective October 1, 2009 the operating unit payment is 100% of the most recent version of the Medicare base payment rates. The Division will revise the base payment rates each year in October when Medicare posts the rates.

(6) DRG Payment: The DRG payment to each Oregon DRG hospital is calculated by adding the unit value to the capital amount, then multiplied by the claim assigned DRG relative weight (out of state hospitals do not receive the capital amount).

(7) Cost Outlier Payments:

(a) Cost outlier payments are an additional payment made to in-state and contiguous hospitals for exceptionally costly services or exceptionally long lengths of stay provided to Title XIX and SF (State Facility) clients;

(b) For dates of service on and after March 1, 2004 the calculation to determine the cost outlier payment for Oregon DRG hospitals is as follows:

(A) Non-covered services (such as ambulance charges) are deducted from billed charges;

(B) The remaining billed charges are converted to hospital-specific costs using the hospital's cost-to-charge ratio derived from the most recent audited Medicare cost report and adjusted to the Medicaid caseload;

(C) If the hospital's net costs as determined above are greater than 270 percent of the DRG payment for the admission and are greater than \$25,000, an additional cost outlier payment is made;

(D) Costs which exceed the threshold (\$25,000 or 270% of the DRG payment, whichever is greater) are reimbursed using the following formula:

(i) Billed charges less non-covered charges, multiplied by;

(ii) Hospital-specific cost-to-charge ratio equals;

(iii) Net Costs, minus;

(iv) 270% of the DRG or \$25,000 (whichever is greater), equals;

(v) Outlier Costs, multiplied by;

(vi) Cost Outlier Percentage, (cost outlier percentage is 50%), equals;

(vii) Cost Outlier Payment;

(E) Third party reimbursements are deducted from the Division calculation of the payable amount;

(F) When hospital cost reports are audited during the cost settlement process, an adjustment will be made to cost outlier payments to reflect the actual Medicaid hospital-specific cost-to-charge ratio during the time cost outlier claims were incurred. The cost-to-charge ratio in effect for that period of time will be determined from the audited Medicare Cost Report and DMAP 42, adjusted to reflect the Medicaid mix of services.

(8) Capital:

(a) The capital payment is a reimbursement to in-state hospitals for capital costs associated with the delivery of services to Title XIX, non-Medicare persons. The Division uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) For the dates of service on and after March 1, 2004 the Capital cost per discharge is one hundred (100) percent of the published Medicare capital rate for fiscal year 2004, see (5). The capital cost is added to the Unit Value and paid per discharge.

(c) Effective October 1, 2009 the Capital cost per discharge is one hundred (100) percent of the current year Medicare capital rate and updated every October thereafter, see (5). The capital cost is added to the Unit Value and paid per discharge.

(9) Direct Medical Education:

(a) The direct medical education payment is a reimbursement to in-state hospitals for direct medical education costs associated with the delivery of services to Title XIX eligible persons. The Division uses the Medicare definition and calculation of direct medical education costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) Direct medical education cost per discharge is calculated as follows:

(A) The direct medical education cost proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986 through June 30, 1987 are divided by the number of Title XIX non-Medicare discharges. This is the Title XIX direct medical education cost per discharge;

(B) The Title XIX direct medical education cost per discharge for this period is inflated forward to January 1, 1992, using the compounded HCFA-DRI market basket adjustment;

(c) Direct medical education payment per discharge:

(A) The number of Title XIX non-Medicare discharges from each hospital for the quarterly period is multiplied by the inflated Title XIX cost per discharge. This determines the current quarter's Direct Medical Education costs. This amount is then multiplied by 85%. Payment is made within thirty days of the end of the quarter;

(B) The Direct Medical Education Payment per Discharge will be adjusted at an inflation factor determined by the Department in consideration of inflationary trends, hospital productivity and other relevant factors.

(C) Notwithstanding subsection (9) of this rule, this subsection becomes effective for dates of service:

(i) On July 1, 2006 and thereafter direct medical education payments will not be made to hospitals; and

(ii) On July 1, 2008 and thereafter direct medical education payments will be made to hospitals, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained.

(10) Indirect Medical Education:

(a) The indirect medical education payment is a reimbursement made to instate hospitals for indirect medical education costs associated with the delivery of services to Title XIX non-Medicare clients;

(b) Indirect medical education costs are those indirect costs identified by Medicare as resulting from the effect of teaching activity on operating costs;

(c) Indirect medical education payments are made to in-state hospitals determined by Medicare to be eligible for such payments. The indirect medical education factor in use by Medicare for each of these eligible hospitals at the beginning of the State's fiscal year is the Division indirect medical education factor. This factor is used for the entire Oregon fiscal year;

(d) For dates of service on and after March 1, 2004 the calculation for the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital specific February 29, 2004 Unit Value, multiplied by the Indirect Factor equals the Indirect Medical Education Payment;

(e) Effective October 1, 2009, the calculation of the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital unit value, see (5)(c), multiplied by the indirect factor equals the Indirect Medical Education Payment.

(f) This determines the current quarter's Indirect Medical Education Payment. Indirect medical education payments are made quarterly to each eligible hospital. Payment for indirect medical education costs will be made within thirty days of the end of the quarter.

(g) Notwithstanding subsection (10) of this rule, this subsection becomes effective for dates of service:

(A) On July 1, 2006 and thereafter Indirect Medical Education payment will not be made to hospitals; and

(B) On July 1, 2008 and thereafter Indirect Medical Education payments will be made to hospitals, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained.

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

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

410-125-1080 Documentation

(1) Federal regulations require Medicaid providers to maintain records that fully support the extent of services for which payment has been requested, and that such records be furnished to the Division upon request (**42 CFR 431.107**).

(2) All applicants for Title XIX or general assistance complete Form DMAP 415A or 415B authorizing the release of any records regarding his or her health. When requested by the Division or its medical review contractor, hospitals must submit sufficient medical documentation to verify the emergency nature, medical necessity, quality and appropriateness of treatment, and appropriateness of the length of stay for inpatient and outpatient hospital services. The Division may request sufficient information to evaluate the accuracy and appropriateness of ~~ICD-9~~ICD-10-CM Coding for the claim. In addition, the Division may request an itemized billing for all services provided. The Division will specify in its request what documentation is required

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

410-125-2020 Post Payment Review

(1) All services provided by a hospital in the inpatient or outpatient setting are subject to post-payment review by the Division. Both emergency and non-emergency services may be reviewed. Claims for services may be reviewed to determine:

- (a) The medical necessity of the admission or outpatient services provided;
- (b) The appropriateness of the length of stay;
- (c) The appropriateness of the plan of care;
- (d) The accuracy of the ~~ICD-9~~ICD-10 coding and DRG assignment;
- (e) The appropriateness of the setting selected for service delivery;
- (f) The quality of care of the services provided;
- (g) The nature of any service coded as emergent;
- (h) The accuracy of the billing;
- (i) The care furnished is appropriately documented.

(2) If the Division determines that a hospital service was not within Division coverage parameters, the hospital and attending physician shall be notified in writing and will have twenty days to provide additional written documentation to support the medical necessity of the admission and/or procedure(s).

(3) If the recommendation for denial is upheld by the Division, the hospital and/or practitioner may request a reconsideration of the denial within 30 days of the receipt of the denial.

(4) If the reconsidered decision is to uphold the denial, payment to all providers of service shall be recovered.

(5) The hospital and/or practitioner may appeal any final decision through the Division administrative appeals process.

(6) No payment shall be made by the Division for inpatient services if the Division or Medicare has determined the service is not medically necessary and/or appropriate.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

**DIVISION 127
HOME HEALTH CARE SERVICES**

410-127-0040

Coverage

(1) Home health services are made available on a visiting basis to eligible clients in their homes as part of a written “plan of care.”

(2) Home health services must be prescribed by a physician and the signed order must be on file at the home health agency. The prescription must include the ~~ICD-9-CM~~ or ICD-10-CM diagnosis code indicating the reason the home health services are requested. The orders on the plan of care must specify the type of services to be provided to the client, with respect to the professional who will provide them, the nature of the individual services, specific frequency and specific duration. The orders must clearly indicate how many times per day, each week and/or each month the services are to be provided. The plan of care must include the client’s condition, the rationale for the care plan including justification for the required skill level of care, and the summary of care for additional certification periods.

(3) The plan of care must be reviewed and signed by the physician every two months to continue services.

(4) The following services or items are covered, if diagnoses are on the portion of the prioritized list above the line funded by the Legislature:

- (a) Skilled nursing services;
- (b) Skilled nursing evaluation (includes Outcome and Assessment Information Set (OASIS) assessment);
- (c) Home Health aide services;
- (d) Occupational therapy services;
- (e) Occupational therapy evaluation (may include OASIS Assessment);
- (f) Physical therapy services;
- (g) Physical therapy evaluation (may include OASIS Assessment);
- (h) Speech and language pathology services (may include OASIS Assessment);
- (i) Speech and language pathology evaluation (may include OASIS assessment);
- (j) Medical/surgical supplies.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

DIVISION 129
SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY AND HEARING AID SERVICES

410-129-0060

Prescription Required

(1) The prescription is the written order by the prescribing practitioner pursuant to state law governing speech-pathology, audiology and hearing aid services. Prescription must specify the ~~ICD-9~~ICD-10-CM diagnosis code for all speech-pathology, audiology and hearing aid services that require payment/prior authorization.

(2) The provision of speech therapy services must be supported by a written order and a therapy treatment plan signed by the prescribing practitioner. A practitioner means a person licensed pursuant to State law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.

(3) A written order:

(a) Is required for the initial evaluation;

(b) For therapy, must specify the ~~ICD-9~~ICD-10-CM diagnosis code, service, amount and duration required.

(4) Written orders must be submitted with the payment (prior) authorization request and a copy must be on file in the provider's therapy record. The written order and the treatment plan must be reviewed and signed by the prescribing practitioner every six months.

(5) Authorization of payment to an audiologist or hearing aid dealer for a hearing aid will be considered only after examination for ear pathology and written prescription for a hearing aid by an ear, nose, and throat specialist (ENT) or general practitioner who has training to examine the ear and performs within the scope of his/her practice, i.e. primary care physician (not appropriate is an orthopedic specialist, chiropractor, gynecologist, etc.).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

**DIVISION 130
MEDICAL-SURGICAL SERVICES**

410-130-0160

Codes

(1) ~~ICD-9~~ICD-10-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~~ICD-10-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

410-130-0190

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~~ICD-10-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

410-130-0562

Abortion

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:

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

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

(3) 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.

(4) Use the most appropriate ~~ICD-9~~ICD-10 diagnosis code.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 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, sub-dermal implants, condoms, and diaphragms.

(6) Bill all family planning services with the most appropriate ~~ICD-9~~ICD-10-CM 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 414.025, 414.065, 414.152

**DIVISION 131
PHYSICAL AND OCCUPATIONAL THERAPY SERVICES**

410-131-0080

Therapy Plan of Care and Record Requirements

- (1) A therapy plan of care is required for prior authorization (PA) for payment.
- (2) The therapy plan of care must include:
 - (a) Client's name, diagnosis, and type, amount, frequency and duration of the proposed therapy;
 - (b) Individualized, measurably objective functional goals;
 - (c) Documented need for extended service, considering 60 minutes as the maximum length of a treatment session;
 - (d) Plan to address implementation of a home management program as appropriate from the initiation of therapy forward;
 - (e) Dated signature of the therapist or the prescribing practitioner establishing the therapy plan of care; and
 - (f) For home health clients, any additional requirements included in Oregon Administrative Rule (OAR) 410 division 127.
- (3) The therapy treatment plan and regimen will be taught to the client, family, foster parents, or caregiver during the therapy treatments. No extra treatments will be authorized for teaching.
- (4) A therapy plan of care shall comply with the relevant state licensing authority's standards.
- (5) If a state licensing authority has not adopted therapy plan of care standards, the therapy plan of care must include:
 - (a) The need for continuing therapy clearly stated;
 - (b) Changes to the therapy plan of care, including changes to duration and frequency of intervention, and
 - (c) Any changes or modifications to the plan of care shall be documented, signed, and dated by the prescribing practitioner or therapist who developed the plan.
- (6) Therapy records must include:
 - (a) A written referral, including:
 - (A) The client's name;
 - (B) The ~~ICD-9~~ICD-10-CM diagnosis code; and
 - (C) Shall specify the type of services, amount, and duration required.
 - (b) A copy of the signed therapy plan of care must be on file in the provider's therapy record prior to billing for services;

(c) Documents, evaluations, re-evaluations, and progress notes to support the therapy treatment plan and prescribing provider's written orders for changes in the therapy treatment plan;

(d) Modalities used on each date of service;

(e) Procedures performed and amount of time spent performing the procedures is documented and signed by the therapist; and

(f) Documentation of splint fabrication and time spent fabricating the splint.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 688.135, 414.065

**DIVISION 133
SCHOOL-BASED HEALTH SERVICES**

410-133-0040

Definitions

- (1) Adapted vehicle — Vehicle specifically designed or modified to transport passengers with disabilities.
- (2) Adequate recordkeeping — In addition to General Rules OAR 410-120-0000, Definitions and 410-120-1360, Requirements for financial, clinical, and other records, documentation in the student's educational record and on the Individualized Education Plan (IEP) or Individualized Family Service Plan(IFSP) showing the necessary and appropriate health services provided to the student detailed in the School-Based Health Services (SBHS) administrative rules (410-133-0000 and 410-133-0320).
- (3) Agent — means a third party or organization that contracts with a provider, allied agency, or Prepaid Health Plan (PHP) to perform designated services in order to facilitate a transaction or conduct other business functions on its behalf. Agents include billing agents, claims clearinghouses, vendors, billing services, service bureaus, and accounts receivable management firms. Agents may also be clinics, group practices, and facilities that submit billings on behalf of providers but the payment is made to a provider, including the following: an employer of a provider, if a provider is required as a condition of employment to turn over his fees to the employer; the facility in which the service is provided, if a provider has a contract under which the facility submits the claim; or a foundation, plan, or similar organization operating an organized health care delivery system, if a provider has a contract under which the organization submits the claim. Agents may also include electronic data transmission submitters.
- (4) Allied Agency — Local and regional governmental agencies and regional authorities that contract with the Department of Human Services (Department) or the Oregon Health Authority (Authority) to provide the delivery of services to covered individuals. (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, public schools, Education Service Districts (ESDs), developmental disability service programs, Area Agencies on Aging (AAAs), federally recognized American Indian tribes).
- (5) Assessment — A process of obtaining information to determine if a student qualifies for or continues to qualify for the Division of Medical Assistance Programs (Division) covered school-based health services.
- (6) Assistive technology service — Services provided by medically qualified staff within the scope of practice under State law with training and expertise in the use of assistive technology (see 410-133-0080 Coverage and 410-133-0200 Not Covered Services in these rules).
- (7) Audiologist — A person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology or holds a Certificate of Clinical Competency (CCC) from the American Speech and Hearing Association (ASHA) and meet the requirements in 42 CFR 440.110.
- (8) Audiology — Assessment of children with hearing loss; determination of the range, nature and degree of hearing loss, including the referral for medical or other professional attention for

restoration or rehabilitation due to hearing disorders; provision of rehabilitative activities, such as language restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determination of the child's need for individual amplification; obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving services.

(9) "Authority" means the Oregon Health Authority (Please see General Rules 410-120-0000 Acronyms and Definitions)

(10) Automated Voice Response (AVR) — A computer system that provides information on clients' current eligibility status from the Division of Medical Assistance Programs by computerized phone or web-based response.

(11) Benefit Package — The "package" of covered health care services for which the Medicaid-eligible student is eligible. (See General Rules OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System)

(12) Billing agent or billing service — Third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider. Also see definition for Electronic Data Interchange (EDI) Submitter

(13) Billing Provider (BP) — A person, agent, business, corporation, clinic, group, institution, or other entity who submits claims to and/or receives payment from the Division of Medical Assistance Programs (Division) on behalf of a performing provider and has been delegated the authority to obligate or act on behalf of the performing provider. (See the Department-wide Support Services (DWSS) administrative rules in, chapter 407, division 120 Provider Rules, and the Division's General Rules OAR 410-120-1260 and SBHS OAR 410-133-0140.)

(14) Billing time limit — Refers to the rules concerning the period of time allowed to bill services to the Division of Medical Assistance Programs (Division) see General Rules OAR 410-120-1300, Timely Submission of Claims. In general, those rules require initial submission within 12 months of the date of service or 18 months for resubmission.

(15) Centers for Medicare and Medicaid Services (CMS) — The federal regulatory agency for Medicaid programs.

(16) CMS-1500 — The standard federal billing form used to bill medical services.

(17) Certification — See "licensure."

(18) Children's Health Insurance Program (CHIP) — A federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered in Oregon by the Oregon Health Authority (Authority) Division of Medical Assistance Programs (Division).

(19) Clinical Social Work Associate (CSWA) — A person working toward Licensed Clinical Social Worker (LCSW) licensure in compliance with Division 20, Procedure for Certification and Licensing, OAR 877-20-0000 through OAR 877-20-0060.

(20) Coordinated care — Services directly related to covered school-based health services (SBHS) specified in the individualized education program (IEP) or individualized family service plan (IFSP), performed by medically qualified staff, and allowed under OAR 410-133-0080,

Coverage, to manage integration of those health services in an education setting. Coordinated care includes the following activities:

(a) Conference — The portion of a conference in a scheduled meeting, between medically qualified staff and interested parties, to develop, review, or revise components of school-based health services provided to a Medicaid-eligible student for the purpose to establish, re-establish or terminate a Medicaid covered health service on a Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP); or to develop, review, or revise components of a health service currently provided to a Medicaid-eligible student to determine whether or not those covered health services continue to meet the student's needs as specified on the student's IEP or IFSP.

(b) Consultation — performed by medically qualified staff within the scope of practice providing technical assistance to or conferring with, special education providers, physicians, and families to assist them in providing a covered health service for Medicaid-eligible students related to a specific health service and health service goals and objectives in the individualized education program (IEP) or individualized family service plan (IFSP).

(c) Physician coordinated care — Meeting or communication with a physician in reference to oversight of care and treatment provided for a health service specified on a Medicaid-eligible student's individualized education program (IEP) or individualized family service plan (IFSP).

(21) Cost Determination — The process of establishing an annual discipline fee (cost rate), based on the prior-year actual audited costs, used by an EA for the purpose of billing for covered school-based health services (see 410-133-0245 Cost Determination and Payment in these rules).

(22) Covered entity — means a health plan, health care clearing house, health care provider, or allied agency that transmits any health information in electronic form in connection with a transaction, including direct data entry (DDE), and who must comply with the National Provider Identifier (NPI) requirements of 45 CFR 162.402 through 162.414. When a school provides covered SBHS services in the normal course of business and bills Medicaid for reimbursed covered transactions electronically in connection with that health care such as electronic claims, it is then a covered entity and must comply with the HIPAA Administrative Simplification Rules for Transactions and Code sets and Identifiers with respect to its transactions.

(23) Current Procedural Terminology (CPT) — The American Medical Association's CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other health care providers. See the Division of Medical Assistance Programs' General Rules Program (OAR 410-120-0000 Definitions).

(24) Data transmission — means the transfer or exchange of data between the Department and a web portal or electronic data interchange (EDI) submitter by means of an information system which is compatible for that purpose and includes without limitation, web portal, EDI, electronic remittance advice (ERA), or electronic media claims (EMC) transmissions.

(25) Delegated Health Care Aide — A non-licensed person trained and supervised by a licensed registered nurse (RN) or nurse practitioner (NP) to perform selected tasks of nursing care specific to the Medicaid-eligible student identified in the nursing plan of care pursuant to the Individualized Education Program/Individualized Family Service Plan (IEP/IFSP).

(26) Delegation of nursing task — A selected nursing task that is performed by an unlicensed person, trained and monitored by a licensed RN. Delegation and supervision of selected nursing tasks must comply with Oregon Administrative Rules (OARs), Board of Nursing, chapter 851, division(s) 45 and 47. A school medical (SM) provider must maintain documentation of the actual delegation, training, supervision and provision of the nursing service billed to Medicaid.

(27) “Department” means the Department of Human Services established in OAR chapter 407, including any divisions, programs and offices as may be established therein.

(28) Diagnosis code — As identified in the International Classification of Diseases 109th Revision, Clinical Modification (ICD-109-CM), the primary Diagnosis Code is shown in all billing claims, unless specifically excluded in individual Division provider rule(s). Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(29) Direct services — Face-to-face delivery of health services between the medically qualified staff who is the service provider and a Medicaid-eligible student.

(30) Division of Medical Assistance Programs (Division) — A Division within the Oregon Health Authority (Authority); the Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children’s Health Insurance Program (SCHIP- Title XXI), and several other programs.

(31) Early Intervention/Early Childhood Special Education (EI/ECSE) – EI is a program designed to address the unique needs of a child age 0-3 years and ECSE is a program for preschool children with a disability ages 3-5 years or eligible for Kindergarten.

(32) Educational Agency (EA) — For purposes of these rules, any public school, school district, Education Service District (ESD), state institution, or youth care center providing educational services to students, birth to age 21 through grade 12, that receives federal or state funds either directly or by contract or subcontract with the Oregon Department of Education (ODE).

(33) Education records — Those records, files, documents and other materials which contain information directly related to a student and maintained by an Education Agency (EA) or by a person acting for such EA as set forth in OAR 581-021-0220. (A school-based health services (SBHS) provider is required to keep and maintain supporting documentation for Medicaid reimbursed school-based health services for a period of seven (7) years; this documentation is part of the student’s education record but may be filed and kept separately by school health professionals.) See 410-133-0320 Documentation and Recordkeeping Requirements in these rules.

(34) Education Service District (ESD) — An education agency established to offer a resource pool of cost-effective, education-related, physical or mental health-related, state-mandated services to multiple local school districts within a geographic area described in ORS 334.010

(35) Electronic Data Interchange (EDI) — The exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Department designates for EDI transactions. For purposes of these rules (OAR 407-120-0100 through 407-120-0200), EDI does not include electronic transmission by web portal.

(36) EDI submitter — An Individual or an entity authorized to establish an electronic media connection with the Department to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner. Also see definition for billing agent in these rules.

(37) Electronic Verification System (EVS) — Eligibility information that have met the legal and technical specifications of the Division of Medical Assistance Programs (Division) in order to offer eligibility information to enrolled Division providers.

(38) Eligibility for special education services — A determination by a designated education agency (EA), through a team, that a child meets the eligibility criteria for early intervention (EI), early childhood special education (ECSE) or special education as defined in ORS 343 and OAR chapter 581, division 15.

(39) Evaluation — Evaluations are procedures performed by medically qualified staff to determine whether a Medicaid-eligible student is disabled and the nature and extent of the health services the student needs under the Individuals with Disabilities Education Act (IDEA) and in accordance with Oregon Department of Education OAR chapter 581 division 15. The Authority can only reimburse evaluations that establish, re-establish or terminate a school-based health services (SBHS) covered health service on a Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA).

(40) Federal Medical Assistance Percentage (FMAP) — The percentage of federal matching dollars for qualified state medical assistance program expenditures.

(41) Healthcare Common Procedure Coding System (HCPCS) — A method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I - American Medical Association's Physician's Current Procedural Terminology (CPT), Level II — National codes, and Level III – Local codes. the Division uses HCPCS codes. See General Rules (OAR 410-120-1280 Billing).

(42) Health assessment plan (nursing) — Systematic collection of data for the purpose of assessing a Medicaid-eligible student's health or illness status and actual or potential health care needs in the educational setting. Includes taking a nursing history, and an appraisal of the student's health status through interview, information from the family and information from the student's past health or medical record. A SBHS provider is required to keep and maintain the health assessment plan and supporting documentation for Medicaid reimbursed health services described in a Medicaid-eligible student's individualized education program (IEP) or individualized family service plan (IFSP) for a period of seven (7) years, as part of the student's education record, which may be filed and kept separately by school health professionals. (See 410-133-0320 Documentation and Recordkeeping Requirements.)

(43) Health care practitioner — A person licensed pursuant to state law to engage in the provision of health care services within the scope of the health care practitioner's license and/or certification standards established by their health licensing agency. Medical provider and health care practitioner are interchangeable terms. See Definition for medical provider in these rules.

(44) Health services — Medical evaluation services provided by a physician for diagnostic and evaluation purposes for a Medicaid-eligible student that is found eligible under the Individuals with Disabilities Education Act (IDEA) and leads to an established Individualized Education

Program (IEP) or Individualized Family service Plan (IFSP), physical or mental health evaluations, and assessment or treatment performed by medically qualified staff to achieve the goals set forth in a Medicaid-eligible student's IEP or IFSP. A covered health service is one that is covered by the medical assistance program and is provided to enable the Medicaid-eligible student to benefit from a special education program (age 3-21) or to achieve developmental milestones in an early intervention program (age 0-3). "Health services" are synonymous with "medical services" in these rules. To determine whether a health service specified on an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) is a covered School-Based Health Service (SBHS) (See 410-133-0080 Coverage and 410-133-0200 Not Covered Services).

(45) Health Services Commission (HSC) — An eleven member commission that is charged with reporting to the Governor the ranking of health benefits from most to least important, and representing the comparable benefits of each service to the entire population to be serviced.

(46) ID number — A number issued by the Authority used to identify Medicaid-eligible students. This number may also be referred to as recipient identification number; prime number; client medical ID Number or medical assistance program ID number.

(47) Individuals with Disabilities Education Act (IDEA) — The federal law ensuring the rights of children with disabilities to a "free and appropriate education" (FAPE).

(48) Individualized Education Plan (IEP) — A written statement of an educational program for a child with a disability which is developed, reviewed, or revised in a meeting in accordance with Oregon Department of Education OAR chapter 581, division 15. When an IEP is used as a prescription for Medicaid reimbursement for covered School-Based Health Services (SBHS), it must include: type of health service, amount, duration and frequency for the service provided. In order to bill Medicaid for covered health services they must be delivered by or under the supervision of medically qualified staff and must be recommended by a physician or appropriate health care practitioner acting within the scope of practice. See definition medically qualified staff.

(49) Individualized Family Service Plan (IFSP) — A written plan of early childhood special education (ECSE) services, early intervention (EI) services, and other services developed in accordance with criteria established by the Oregon Department of Education (ODE) for each child (age's birth to 5 years) eligible for IFSP services. The plan is developed to meet the needs of a child with disabilities in accordance with requirements and definitions in OAR chapter 581, division 15. When an IFSP is used as a prescription for Medicaid reimbursement for SBHS covered services, it must include: type of health service, amount, duration and frequency for the service provided. In order to bill Medicaid for covered health services they must be delivered by or under the supervision of medically qualified staff and must be recommended by a physician or appropriate health care practitioner acting within their scope of practice. See definition medically qualified staff.

(50) Individualized Education Plan/Individualized Family Service Plan (IEP/IFSP) Team — A group of teachers, specialists, and parents responsible for determining eligibility, developing, reviewing, and revising an IEP or IFSP in compliance with the Oregon Department of Education (ODE) OAR chapter 581, division 15.

(51) Licensed Clinical Social Worker (LCSW) — A person licensed to practice clinical social work pursuant to State law.

(52) Licensed Physical Therapist Assistant (LPTA) — A person licensed to assist in the administration of physical therapy, solely under the supervision and direction of a physical therapist.

(53) Licensed Practical Nurse (LPN) — A person licensed to practice under the direction of a licensed professional within the scope of practice as defined by State law.

(54) Licensure — Documentation from state agencies demonstrating that licensed or certified individuals are qualified to perform specific duties and a scope of services within a legal standard recognized by the licensing agency. In the context of health services, licensure refers to the standards applicable to health service providers by health licensing authorities. For health services provided in the state of Oregon, licensure refers to the standards established by the appropriate State of Oregon licensing agency.

(55) Medicaid-eligible student — The child or student who has been determined to be eligible for Medicaid health services by the Authority. For purposes of this rule, Medicaid-eligible student is synonymous with “recipient” or “Oregon Health Plan (OHP) client”. For convenience, the term student used in these rules applies to both students covered by an Individualized Education Program (IEP) and children covered by an Individualized Family Service Plan (IFSP). Also for purposes of this rule, students or children whose eligibility is based on the Children’s Health Insurance Program (CHIP) shall be referred to as Medicaid-eligible students.

(56) Medical Assistance Program — A program for payment of health services provided to eligible Oregonians. Oregon’s medical assistance program includes Medicaid services including the Oregon Health Plan (OHP) Medicaid Demonstration, and the Children’s Health Insurance Program (CHIP). The Medical Assistance Program is administered by the Division of Medical Assistance Programs (Division), of the Oregon Health Authority.

(57) Medical Management Information System (MMIS) — A data collection system for processing paper and electronic claims for payment of health services provided to Medicaid-eligible recipients.

(58) Medical provider — An individual licensed by the State to provide health services within their governing body's definitions and respective scope of practice. Medical provider and health care practitioner are interchangeable terms.

(59) Medical services — The care and treatment provided by a licensed health care practitioner to prevent, diagnose, treat, correct or address a medical problem; whether physical, mental or emotional. For the purposes of these rules, this term shall be synonymous with health services or health-related services listed on an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), as defined in OAR chapter 581, division 15. Not all health-related services listed on an IEP or IFSP are covered as SBHS. See 410-133-0080 Coverage and 410-133-0200 Not Covered Services.

(60) Medical transportation — Specialized transportation in a vehicle adapted to meet the needs of passengers with disabilities transported to and from a SBHS covered service.

(61) Medically qualified staff:

(a) Staff employed by and/or through contract with an EA; and

(b) Licensed by the State to provide health services in compliance with State law defining and governing the scope of practice, described further in OAR 410-133-0120.

(62) Medication management — A task performed only by medically qualified staff, pursuant to a student’s Individualized Education Program/Individualized Family Service Plan (IEP/IFSP), which involves administering medications, observing for side effects, and monitoring signs and symptoms for medication administration.

(63) National Provider Identification (NPI) — Federally directed Provider number mandated for use on Health Insurance Portability Accountability Act (HIPAA) covered transactions; individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI; Medicare covered entities are required to apply for an NPI.

(64) “Necessary and appropriate” health services — Those health services described in a Medicaid-eligible student’s IEP or IFSP which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of the Medicaid-eligible student or provider of the service; and

(d) The most cost-effective of the alternative levels of health services, which can safely be provided to a Medicaid-eligible student.

(65) Nursing Diagnosis and Management Plan — A written plan that describes a Medicaid-eligible student’s actual and anticipated health conditions that are amenable to resolution by nursing intervention.

(66) Nursing Plan of Care — Written guidelines that are made a part of, and attached to the Individualized Education Program (IEP) or individualized Family Service Plan (IFSP) that identify specific health conditions of the Medicaid-eligible student, and the nursing regimen that is “necessary and appropriate” for the student. Development and maintenance of this plan includes establishing student and nursing goals, and identifying nursing interventions (including location, frequency, duration and delegation of care) to meet the medical care objective identified in their IEP or IFSP, see Oregon State Board of Nursing Practice Act, Division 47. The SBHS provider is responsible for developing the nursing plan of care and is required to keep and maintain a copy of the nursing plan of care as supporting documentation for Medicaid reimbursed health services. (See definition “Education records”.)

(67) Nurse practitioner — A person licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to State law.

(68) Nursing services — Services provided by a nurse practitioner (NP), registered professional nurse (RN), a licensed practical nurse (LPN) or delegated health care aide, within the scope of practice as defined by State law. Nursing services include preparation and maintenance of the health assessment plan, nursing diagnosis and management plan, nursing plan of care, consultation, and coordination and integration of health service activities, as well as direct patient care and supervision.

(69) Observation — Surveillance or visual monitoring performed by medically qualified staff as part of an evaluation, assessment, direct service, or care coordination for a necessary and

appropriate Medicaid covered health service specified on a Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) to better understand the child's medical needs and progress in their natural environment. An observation by itself is not billable.

(70) Occupational therapist (OT) — A person licensed by the State's Occupational Therapy Licensing Board.

(71) Occupational Therapist Assistant — A person who is licensed as an occupational therapy assistant assisting in the practice of occupational therapy under the supervision of a licensed occupational therapist.

(72) Occupational therapy — Assessing, improving, developing, or restoring functions impaired or lost through illness, injury or deprivation, to improve the ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention, initial or further impairment or loss of function. Obtaining and interpreting information, coordinating care, and integrating necessary and appropriate occupational therapy services relative to the Medicaid-eligible student.

(73) Oregon Department of Education (ODE) — The state agency that provides oversight to public educational agencies for ensuring compliance with Federal and State laws relating to the provision of services required by the individuals with disabilities education act (IDEA).

(74) Orientation and mobility training — Services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environments in school, home, and community. These services are not covered under School-Based Health Services (SBHS) (See OAR 410-133-0200 Not Covered Services).

(75) Performing provider — A person, agent, business, corporation, clinic, group, institution, or other entity that is the provider of a service or item with the authority to delegate fiduciary responsibilities to a billing provider, also termed billing agent, to obligate or act on the behalf of the performing provider regarding claim submissions, receivables, and payments relative to the Medical Assistance Program. For the purposes of these SBHS rules, the school medical (SM) provider is the performing provider.

(76) Physical Therapist — A person licensed by the relevant State licensing authority to practice physical therapy (See OAR chapter 848, division 10 Licensed Physical Therapists and Licensed Physical therapist Assistants; chapter 848 division, 040 Minimum Standards For Physical therapy Practice and Records

(77) Physical Therapy — Assessing, preventing or alleviating movement dysfunction and related functional problems. Obtaining and interpreting information: coordinating care and integrating necessary and appropriate physical therapy services relative to the student receiving treatments.

(78) Prime Number — See definition of ID Number.

(79) Prioritized List of Health Services — Also referred to as the Prioritized List, the Oregon Health Services Commission's (HSC) listing of health services with "expanded definitions" of ancillary services and preventative services and the HSC practice guidelines, as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by the HSC. The Prioritized List governs medical assistance programs' health services and Benefit

Packages pursuant to the Division of Medical Assistance Programs' General Rules OAR 410-120-0000 et seq., and OAR 410-141-0480 through 410-141-0520 (for the listing of condition and treatment pairs).

(80) Procedure code — See definition of HCPC healthcare common procedure code.

(81) Provider — An individual, facility, institution, corporate entity, or other organization which supplies health care services or items, also termed a performing provider, or bills, obligates and receives reimbursement on behalf of a performing provider of services, also termed a billing provider (BP). The term "Provider" refers to both performing providers and billing providers unless otherwise specified. Payment can only be made to Division-enrolled providers who have by signature on the provider enrollment forms and attachments, agreed to provide services and to bill in accordance with General Rules OAR 410-120-1260, and the SBHS OAR 410-133-0140. If a provider submits claims electronically, the provider must become a trading partner with the Authority and comply with the requirements of the Electronic Data Interchange (EDI) rules pursuant to OAR 407-120-0100 through 407-120-0200.

(82) Provider enrollment agreement — An agreement between the provider and the Oregon Health Authority (Authority) that sets forth the conditions for being enrolled as a provider with the Authority and to receive a provider number in order to submit claims for reimbursement for covered SBHS provided to Medicaid-eligible students. Payment can only be made to Division of Medical Assistance Programs' (Division)-enrolled providers who have by signature on the provider enrollment forms and program applicable attachments agree to provide services and to bill in accordance with Provider Rules chapter 407, division 120 and the Division's General Rules chapter 410, division 120, and these SBHS rules. Also see definitions for Trading Partner and Trading Partner Agreement in these rules.

(83) Psychiatrist — A person licensed to practice medicine and surgery in the state of Oregon and possesses a valid license from the Oregon Licensing Board for the Healing Arts.

(84) Psychologist — A person with a doctoral degree in psychology and licensed by the State Board of Psychologist Examiners See 858-010-0010.

(85) Psychologist Associate — A person who does not possess a doctoral degree that is licensed by the Board of Psychologists Examiners, to perform certain functions within the practice of psychology under the supervision of a psychologist. See 858-010-0037 through 858-010-0038. An exception would be psychologist associate with the authority to function without immediate supervision, see OAR 858-010-0039.

(86) Recordkeeping requirements — A SBHS SM provider is required to keep and maintain the supporting documentation for Medicaid reimbursed health services described in a Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) for a period of seven (7) years, as part of the student's education record, which may be filed and kept separately by school health professionals (See OAR 410-133-0320).

(87) Re-evaluation — Procedures used to measure a Medicaid-eligible student's health status compared to an initial or previous evaluation, are focused on evaluation of progress toward current goals, modifying goals or treatment, or making a professional judgment to determine whether or not the student will continue to receive continued care for a covered service pursuant to an IEP or IFSP under the Individuals with Disabilities Education Act (IDEA). Continuous assessment of the student's progress as a component of ongoing therapy services is not billable as a re-evaluation.

(88) Regional program — Regional program services are provided on a multi-county basis, under contract from the Oregon Department of Education (ODE) to eligible children (birth to 21) visually impaired, hearing impaired, deaf-blind, autistic, and/or severely orthopedically impaired. A regional program may be reimbursed for covered health services it provides to Medicaid-eligible students through the school medical (SM) provider (e.g., public school district or ESD) that administers the program.

(89) Registered Nurse (RN) — A person licensed and certified by the Oregon Board of Nursing to practice as a registered nurse pursuant to State law.

(90) Rehabilitative services — For purposes of the School-Based Health Services (SBHS) program, any health service that is covered by the Medical Assistance Program and that is a medical, psychological or remedial health service recommended by a physician or other licensed health care practitioner within the scope of practice under State law, and provided to a Medicaid-eligible student pursuant to an Individualized Education Program/Individualized Family Service Plan (IEP/IFSP) under the Individuals with Disabilities Education Act (IDEA), for reduction, correction, stabilization or functioning improvement of physical or mental disability of a Medicaid-eligible student (See 410-133-0060).

(91) Related services — For purposes of this rule, related services as listed on an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) may include: transportation and such developmental, corrective and other supportive services (e.g., speech language, audiology services, psychological services, physical therapy, occupational therapy, social work services in schools, and nursing services) as are required to assist a child or student with a disability to benefit from special education; and includes early identification and assessment of disabling conditions in children. NOTE: Not all "related services" are covered for payment by Medicaid. To determine whether a particular related service is a covered health service for a Medicaid-eligible student (see OAR 410-133-0080, Coverage and OAR 410-133-0200, Not Covered Services).

(92) School-Based Health Services (SBHS) — Health services provided in the educational setting, meeting the requirements of these rules, and applicable federal and state laws and rules.

(93) School medical (SM) provider — An enrolled provider type established by the Division to designate the provider of school-based health services eligible to receive reimbursement from the Division. See the Authority's general rules chapter 943 division 120, the Division's General Rules OAR 410-120-1260, and School-Based Health Services Program OAR 410-133-0140 (School Medical (SM) Provider Enrollment Provisions).

(94) Screening — A limited examination to determine a Medicaid-eligible student's need for a diagnostic medical evaluation. See OAR 410-133-0200 (Not Covered Services).

(95) Special Education Services — Specially designed instruction to meet the unique needs of a child with a disability, including regular classroom instruction, instruction in physical education, home instruction, and instruction in hospitals, institutions, special schools, and other settings.

(96) Speech Language Pathology Assistant (SLPA) — A person who is licensed by the Oregon State Board of Examiners for Speech Pathology and Audiology and provides speech-language pathology services under the direction and supervision of a speech-language pathologist licensed under ORS 681.250.

(97) Speech-Language Pathologist — A person licensed by the Oregon Board of Examiners for Speech Pathology and Audiology or holds a Certificate of Clinical Competency (CCC) from the American Speech and Hearing Association (ASHA) (See Medically Qualified Staff 410-133-0120).

(98) Speech-language pathology services — Assessment of children with speech/language disorders, diagnosis and appraisal of specific speech/language disorders, referral for medical and other professional attention necessary for the rehabilitation of speech/language disorders and provision of speech/language services for the prevention of communicative disorders. Obtaining and interpreting information, coordinating care, and integrating necessary and appropriate speech-language pathology services relative to the student receiving services.

(99) State Education Agency (SEA) — See “Oregon Department of Education (ODE)”.

(100) State-operated school — The Oregon School for the Deaf. See “Educational Agency.”

(101) Student health/medical/nursing records — Education records that document, for Medical Assistance Program purposes, the Medicaid-eligible student’s diagnosis or the results of tests, screens or treatments, treatment plan, the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), and the record of treatments or health services provided to the child or student.

(102) Teachers' Standards and Practices Commission (TSPC) — The Commission that governs licensing of teachers, personnel, service specialists, and administrators as set forth in OAR chapter 584. In order for schools or school providers to participate in the Medicaid program and receive Medicaid reimbursement, they must meet the Medicaid provider qualifications. It is not sufficient for a state to use Department of Education provider qualifications for reimbursement of Medicaid-covered health services provided in an education setting.

(103) Testing — See "Assessment".

(104) Testing Technician — A person/technician adequately trained to administer and score specific tests, as delegated under the direction and supervision of a licensee, and maintains standards for the testing environment and testing administration as set forth in the American Psychological Association Standards for Educational and Psychological Tests (1999) and Ethical Principles for Psychologists (2002). See ORS 675.010(4), OAR 858-010-0001, and 858-010-0002.

(105) Third-party billing — A process of sending a bill to a public or private insurance company for a medical or health service given to someone who is insured.

(106) Trading partner — means a provider, prepaid health plan (PHP), clinic, or allied agency that has entered into a trading partner agreement with the Department in order to satisfy all or part of its obligations under a contract by means of electronic data interchange (EDI), electronic remittance advice (ERA), or electronic media claims (EMC), or any other mutually agreed means of electronic exchange or transfer of data. EDI transactions must comply with the requirements of the EDI rules OAR 407-120-0100 through 407-120-0200 for the purposes of these rules EDI does not include electronic transmission by web portal.

(107) Trading partner agreement (TPA) — means a specific request by a provider, PHP, clinic, or allied agency to conduct EDI transactions that governs the terms and conditions for EDI transactions in the performance of obligations under a contract. A provider, PHP, clinic, or

allied agency that has executed a TPA will be referred to as a trading partner in relation to those functions.

(108) Transportation Aide — An individual trained for health and safety issues to accompany a Medicaid-eligible student transported to and from a covered Health Service as specified in the Individualized Education Program/individualized Family Service Plan (IEP/IFSP). The School Medical (SM) Provider must maintain documentation of the training, supervision and provision of the services billed to Medicaid. For the purposes of these rules, individual transportation aides are included in the cost calculation for transportation costs and will not be billed separately. This computation will not include delegated health care aides for whom costs are direct costs.

(109) Transportation as a related service — Specialized transportation adapted to serve the needs of a Medicaid-eligible student to and from a covered health service that is necessary and appropriate, and described in the Individualized Education Program/individualized Family Service Plan (IEP/IFSP) as outlined in OAR 410-133-0080 (Coverage).

(110) Transportation vehicle trip log — A record or log kept specifically for tracking each transportation trip a Medicaid-eligible student receives transportation to or from a covered health service. (See OAR 410-136-0280 Medical Transportation rules – Required Documentation and SBHS OAR 410-133-0245, Cost Determination and Payment).

(111) Treatment Plan — A written plan of care services, including treatment with proposed location, frequency and duration of treatment as required by the health care practitioner's health licensing agency.

(112) Unit — Is a service measurement of time for billing and reimbursement efficiency. One (1) unit equals 15 minutes unless otherwise stated.

(113) Web Portal submitter — means an individual or entity authorized to establish an electronic media connection with the Department of Human Services to conduct a direct data entry transaction. A web portal submitter may be a provider or a provider's agent.

Stat. Auth.: ORS 413.042

Stats. Implemented: 413.042 & 414.065

DIVISION 140 VISUAL SERVICES

410-140-0040

Prior Authorization

(1) Prior Authorization (PA) is defined in Oregon Administrative Rule (OAR) 410-120-0000 Acronyms and Definitions. Providers must obtain a PA from the:

(a) Enrolled member's Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO) (See OAR 410-140-0020 and refer to 410-120-0250, PHP or CCOs.); and

(b) Division of Medical Assistance Programs (Division) for clients who receive services on a fee-for-services basis and are not enrolled with a PHP or CCO.

(2) A PA does not guarantee eligibility or reimbursement. It is the responsibility of the provider to verify the client's eligibility on the date of service and whether a PHP, CCO or the Division is responsible for reimbursement. Refer to OAR 410-120-1140 Verification of Eligibility.

(3) A PA is not required for clients with both Medicare and Division coverage when the service or item is covered by Medicare.

(4) It is the provider's responsibility to determine if a PA is required and to comply with all PA requirements outlined in these Visual Services administrative rules. See also OAR 410-120-1320 Authorization of Payment.

(5) It is the provider's responsibility to ensure:

(a) PA requests are completed and submitted correctly. The Division does not accept PA requests via the phone. Refer to the Visual Services Supplemental Information Guide found on this Division website at <http://www.dhs.state.or.us/policy/healthplan/guides/vision/main.html>;

(b) PA requests include:

(A) A statement of medical appropriateness showing the need for the item or service and why other options are inappropriate;

(B) Diopter information and appropriate International Classification of Diseases, 109th revision, Clinical Modification (~~ICD-9~~ICD-10-CM) diagnosis codes;

(C) All relevant documentation that is needed for Division staff to make a determination for authorization of payment, including clinical data or evidence, medical history, any plan of treatment, or progress notes;

(c) The service is adequately documented. (See OAR 410-120-1360 Requirements for Financial, Clinical and Other Records.) Providers must maintain documentation in the provider's files to adequately determine the type, medical appropriateness, or quantity of services provided;

(d) The services or items provided are consistent with the information submitted when authorization was requested;

(e) The services billed are consistent with those services provided; and

(f) The services are provided within the timeframe specified on the authorization of payment document.

(6) It is the providers' responsibility to comply with the Division's PA requirements or other policies necessary for reimbursement before providing services to any OHP client who is not enrolled in a PHP. Services or items denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.), cannot be billed to the client. (See OAR 410-120-1280.)

(7) Vision services requiring PA include:

(a) Contact lenses for adults (age 21 and older) and excludes a primary keratoconus diagnosis, which is exempt from the PA requirement. See OAR 410-140-0160 Contact Lens Services for service and supply coverage and limitations;

(b) Vision therapy greater than six sessions. Six sessions are allowed per calendar year without PA. See also 410-140-0280 Vision Therapy Services; and

(c) Specific vision materials (See OAR 410-140-0260 Purchase of Ophthalmic Materials for more information.):

(A) Frames not included in the Division's contract with contractor, SWEEP Optical;

(B) Deluxe frames; and

(C) Specialty lenses or lenses considered as "not otherwise classified" by Health Care Common Procedure Coding System (HCPCS);

(d) An unlisted ophthalmological service or procedure, or "By Report" (BR) procedures.

(8) The Division sends Notice of all approved PA requests for vision materials to DMAP's contractor, SWEEP Optical; who forwards a copy of the PA approval and confirmation number to the requesting provider. (See OAR 410-140-0260 Purchase of Ophthalmic Materials.)

(9) Table 140-0040-1. [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 683.010 & 743.842

410-140-0120

~~ICD-9~~ICD-10-CM Diagnosis, CPT/HCCPs Procedure Codes, and Modifiers

(1) The Division of Medical Assistance Program (Division) requires an International Classification of Diseases, 109th revision, Clinical Modification (~~ICD-9~~ICD-10-CM) diagnosis code on all claims. Refer to OAR 410-120-1280 Billing for diagnosis code requirements.

(2) Providers are responsible to provide the client's diagnosis to ancillary service providers (e.g. SWEEP Optical Laboratories) when prescribing services, equipment, and supplies.

(3) The Division requires providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Providers are required to accurately code claims using the combination of Health Care Common Procedure Coding System (HCCPS) and Current Procedural Terminology (CPT) codes in effect for the date the service(s) was provided:

(a) Providers shall comply with published guidelines. Providers may not bill CPT or HCCPS procedure codes for separate procedures when a single CPT or HCCPS code includes all services provided.

(b) Intermediate and comprehensive ophthalmological services as described under the ophthalmology section of the CPT codebook shall be billed using codes included under this section and not those included under the Evaluation and Management section.

(c) When there is no appropriate descriptive procedure code to bill the Division, the provider shall use the code for "unlisted services." See OAR 410-140-0040 Prior Authorization.

(4) The Division recognizes HIPAA compliant modifiers.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

410-140-0260

Purchase of Glasses

(1) The Division of Medical Assistance Programs (Division) contracts with SWEEP Optical Laboratories (also referred to herein as contractor) to buy vision materials (e.g., frames, lenses and miscellaneous items), excluding contact lenses. (See OAR 410-140-0160 Contact Lens Services and Supplies.) Rates for materials are negotiated by the Oregon Department of Administrative Services. All frames, lenses and miscellaneous items are to be provided:

(a) Only by contractor, unless the client has primary Medicare coverage; or

(b) By any visual materials supplier when the client has primary Medicare coverage for a Medicare-covered item. See Oregon Administrative Rule (OAR) 410-140-0080 Medicare/Medicaid Assistance Program Claims; and

(c) It is the provider's responsibility to verify the client's eligibility prior to ordering vision materials. See OAR 410-140-0050 Eligibility and Benefit Coverage and refer to 410-120-1140 Verification of Eligibility.

(2) Buying-up, defined in OAR 410-120-0000 Acronyms and Definitions, is prohibited. See 410-120-1350 Buying Up.

(3) The Division covers glasses for:

(a) Eligible adults (age 21 and older) once every 24 months (see OAR 410-140-0050).

(b) Clients once within 120 days following cataract surgery. When ordering glasses from contractor, the date of surgery is required on the order form.

(c) Eligible children (birth through age 20) without limitation when it is documented in the physician's or optometrist's clinical record as medically appropriate.

(4) Division non-covered ophthalmic materials include, but are not limited to, the following:

(a) Glasses with a prescription that is equal to or less than +/- .25 diopters in both eyes are not covered;

(b) Two pair of glasses in lieu of bifocals or trifocals in a single frame;

(c) Hand-held, low vision aids;

(d) Non-spectacle mounted aids;

(e) Single lens spectacle mounted low vision aids;

(f) Telescopic and other compound lens systems, including distance vision telescopic, near vision telescopes and compound microscopic lens systems;

(g) Extra or spare pairs of glasses;

(h) Anti-reflective lens coating;

(i) U-V lens;

(j) Progressive and blended lenses;

(k) Bifocals and trifocals segments over 28mm including executive;

(l) Aniseikonic lenses;

(m) Sunglasses; and

(n) Frame styles outside of the contract between the Division and contractor based on client preference and are not medically necessary.

(5) Costs for the following are included in reimbursement for the lens and are not separately reimbursed by the Division:

(a) Scratch coating;

(b) Prism;

(c) Special base curve; and

(d) Tracings.

(6) Materials that require Prior Authorization (PA) are included in OAR 410-140-0040 Prior Authorization.

(7) If a frame cannot be located in the contractor's catalog at www.sweepoptical.com that meets the medical needs of the client:

(a) Providers should contact contractor for assistance with locating a frame to meet the client's need; and

(b) Frames not included in the contract between the Division and contractor may be purchased through contractor with prior authorization.

(8) Contractor is not responsible if the Division determines the documentation in the client's record does not allow for the service as directed by the limitations indicated in the administrative rules.

(9) The following services do not require PA, are subject to strict limitations and require the physician or optometrist to submit appropriate documentation to contractor:

(a) Replacement parts (e.g., frame fronts, cable temple arm) for non-contracted frame styles are limited to frames purchased with prior authorization approval. See section (7) of this rule;

(b) Tints and Photochromic lenses: Limited to clients with documented albinism and pupillary defects. Documentation provided to contractor shall include the most appropriate International Classification of Diseases, 10⁹th Revision, Clinical Modification (~~ICD-9~~ICD-10-CM) code selected by a physician or optometrist;

(c) Other medically necessary items for a contract frame (i.e., cable temples, head-strap frame), when a client has a medical condition that requires the use of a specialty temple, nose pieces, head strap frame;

(d) Nonprescription glasses: Limited to clients that do not require any correction in one eye and where there is blindness in one eye. The purpose of this exception is to offer maximum protection for the remaining functional eye;

(e) High Index Lenses:

(A) Power is +/- 10 or greater in any meridian in either eye; or

(B) Prism diopters are 10 or more diopters in either lens;

(f) Polycarbonate lenses are limited to the following populations:

(A) Eligible children (birth through age 20);

(B) Clients with developmental disabilities; and

(C) Clients who are blind in one eye and need protection for the other eye, regardless of whether a vision correction is required.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 279A.140, 414.025 & 414.065

DIVISION 141
Oregon Health Plan (MCO and CCO) Program

410-141-0480

Oregon Health Plan Benefit Package of Covered Services

- (1) Division members are eligible to receive, subject to section (11) of this rule, those treatments for the condition/treatment pairs funded on the Health Evidence Review Commission (HERC) Prioritized List of Health Services adopted under OAR 410-141-0520 when such treatments are medically or dentally appropriate, except that services shall also meet the prudent layperson standard defined in 410-141-0140. Refer to 410-141-0520 for funded line coverage information.
- (2) Medical Assistance Benefit Packages follow practice guidelines adopted by the HERC in conjunction with the Prioritized List of Health Services unless otherwise specified in rule.
- (3) Diagnostic services that are necessary and reasonable to diagnose the member's presenting condition are covered services regardless of the placement of the condition on the Prioritized List of Health Services.
- (4) Comfort care is a covered service for a member with a terminal illness.
- (5) Preventive services promoting health and reducing the risk of disease or illness are covered services for members. These services include, but are not limited to, periodic medical and dental exams based on age, sex, and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors (See OAR 410-141-0520 Prioritized List of Health Services).
- (6) Ancillary services are covered subject to the service limitations of the OHP program rules when the services are medically or dentally appropriate for the treatment of a covered condition/treatment pair, or the provision of ancillary services will enable the member to retain or attain the capability for independence or self-care.
- (7) The provision of SUD services shall comply with Addictions and Mental Health Division (AMH) administrative rules, OAR 415-012-0000 "Standards for Approval/Licensure of Alcohol and Other Drug Abuse Programs," OAR 415-020 "Standards for Outpatient Synthetic Opiate Treatment Programs," OAR 415-050 "Standards for Alcohol Detoxification Centers," OAR 309-018 "Residential Substance Use Disorders and Problem Gambling Treatment and Recovery Services," OAR 309-019 "Outpatient Addictions and Mental Health Services," OAR 309-022 "Intensive Treatment Services for Children and Adolescents and Children's Emergency Safety Intervention Specialist," and the requirements in the SUD subsection of the Statement of Work in the CCO, FCHP, and PCO contracts.
- (8) In addition to the coverage available under section (1) of this rule, a member may be eligible to receive, subject to section (11), services for treatments that are below the funded line or not otherwise excluded from coverage:
 - (a) Services may be provided if it can be shown that:

(A) The OHP member has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and

(B) Concurrently has a medically related unfunded condition that is causing or exacerbating the funded condition; and

(C) Treating the unfunded medically related condition would significantly improve the outcome of treating the funded condition;

(D) Ancillary services that are excluded and other services that are excluded are not subject to consideration under this rule;

(E) Any unfunded or funded co-morbid conditions or disabilities shall be represented by an ~~ICD-9~~ICD-10-CM diagnosis code or when the condition is a mental disorder, represented by DSM-V diagnosis coding to the highest level of axis specificity; and

(F) In order for the treatment to be covered, there shall be a medical determination and finding by the Division for fee-for-service OHP clients or a finding by the Prepaid Health Plan (PHP) for members that the terms of subsection (a)(A)–(C) of this rule have been met based upon the applicable:

(i) Treating physician opinion;

(ii) Medical research;

(iii) Community standards; and

(iv) Current peer review.

(b) Before denying treatment for an unfunded condition for any member, especially a member with a disability or with a co-morbid condition, providers shall determine whether the member has a funded condition/treatment pair that would entitle the member to treatment under the program, and both the funded and unfunded conditions shall be represented by an ICD- ~~109~~CM diagnosis code, or when the condition is a mental disorder, represented by DSM-V diagnosis coding to the highest level of axis specificity.

(9) The Division shall maintain a telephone information line for the purpose of providing assistance to practitioners in determining coverage under the OHP Benefit Package of Covered Services. The telephone information line shall be staffed by registered nurses who shall be available during regular business hours. If an emergency need arises outside of regular business hours, the Division shall make a retrospective determination under this section, provided the Division is notified of the emergency situation during the next business day. If the Division denies a requested service, the Division shall provide written notification and a notice of the right to an administrative hearing to both the OHP member and the treating physician within five working days of making the decision.

(10) If a condition/treatment pair is not on the HERC Prioritized List of Health Services and the Division determines the condition/treatment pair has not been identified by the HERC for inclusion on the list, the Division shall make a coverage decision in consultation with the HERC.

(11) Coverage of services available through the OHP Benefit Package of Covered Services is limited by OAR 410-141-0500 (Excluded Services and Limitations for Oregon Health Plan Clients).

(12) General anesthesia for dental procedures that are medically and dentally appropriate to be performed in a hospital or ambulatory surgical setting may be used only for those members as detailed in OAR 410-123-1490.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

**DIVISION 146
AMERICAN INDIAN/ALASKA NATIVE**

410-146-0040

~~ICD-9~~ICD-10-CM Diagnosis Codes and CPT/HCPCs Procedure Codes

(1) The Division of Medical Assistance Program (Division) requires diagnosis codes on all claims, including those submitted by independent laboratories and portable radiology, including nuclear medicine and diagnostic ultrasound providers. A clinic must always provide the client's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(2) The appropriate ICD-10-CM code ~~or codes from 001.0Q87.1 through V82.9Z99.89~~ must be used to identify:

(a) Diagnoses;

(b) Symptoms;

(c) Conditions;

(d) Problems;

(e) Complaints; or

(f) Other reasons for the encounter/visit.

(3) Clinics must list the principal diagnosis in the first position on the claim. Use the principal diagnosis code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Clinics may list up to three additional diagnosis codes on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect client care, treatment, or management.

(4) Clinics must list the diagnosis codes using the highest degree of specificity available in the ~~ICD-9~~ICD-10-CM. ~~Use a three-digit code only if the diagnosis code is not further subdivided. Whenever fourth-digit or fifth-digit subcategories are provided, the provider must report the diagnosis at that specificity.~~ The Division considers a diagnosis code invalid if it has not been coded to its highest specificity.

(5) The Division requires providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards in effect for the date the service(s) was provided.

(a) For dental services, use codes that are in effect for the date the services(s) was provided that are found in Dental Procedures and Nomenclature as maintained and distributed by the American Dental Association;

(b) For health care services, use the combination of Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes in effect for the date the services(s) was provided. These services include, but are not limited to, the following:

(A) Physician services;

- (B) Physical and occupational therapy services;
- (C) Radiology procedures;
- (D) Clinical laboratory tests;
- (E) Other medical diagnostic procedures;
- (F) Hearing and vision services.

(6) The Division maintains unique coding and claim submission requirements for administrative exams and Death With Dignity services. Refer to OAR 410 division 150, Administrative Examination and Billing Services, and OAR 410-130-0670, Death with Dignity Services for specific requirements.

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

410-146-0085

Encounter and Recognized Practitioners

(1) The Division of Medical Assistance Programs (Division) will reimburse enrolled American Indian/Alaska Native (AI/AN) providers as follows:

(a) For services, items and supplies that meet the criteria of a valid encounter in sections (5) through (7) of this rule;

(b) Reimbursement is limited to the Division's Medicaid-covered services according to a client's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act. Other services that are not defined in this rule or the State Plan under Title XIX or Title XXI of the Social Security Act are not reimbursed by the Division.

(2) AI/AN providers reimbursed according to a cost-based rate under the Prospective Payment System (PPS) are directed to Oregon administrative rule (OAR) 410-147-0120, Encounter and Recognized Practitioners, in the Division's Federally Qualified Health Centers and Rural Health Clinics Program.

(3) AI/AN providers reimbursed according to the IHS rate are subject to the requirements of this rule.

(4) Services provided to Citizen/Alien-Waived Emergency Medical (CAWEM) and Qualified Medicare Beneficiary (QMB) only clients are not billed according to encounter criteria and not reimbursed at the IHS encounter rate (refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System).

(5) For the provision of services defined in Titles XIX and XXI, and provided through an IHS or Tribal 638 facility, an "encounter" is defined as a face-to-face or telephone contact between a health care professional and an eligible OHP client within a 24-hour period ending at midnight, as documented in the client's medical record. Section (7) of this rule outlines limitations for telephone contacts that qualify as encounters.

(6) An encounter includes all services, items and supplies provided to a client during the course of an office visit, and "incident-to" services (except as excluded in section (15) of this

rule). The following services are inclusive of the visit with the core provider meeting the criteria of a reimbursable valid encounter and are not reimbursed separately:

(a) Drugs or medication treatments provided during the clinic visit, with the exception of contraception supplies and medications as costs for these items are excluded from the IHS encounter rate calculation (refer to OAR 410-146-0200, Pharmacy);

(b) Medical supplies, equipment, or other disposable products (e.g. gauze, band-aids, wrist brace); and

(c) Venipuncture for laboratory tests.

(7) Telephone encounters only qualify as a valid encounter for services provided in accordance with OAR 410-130-0595, Maternity Case Management (MCM) and OAR 410-130-0190, Tobacco Cessation (refer to OAR 410-120-1200). Telephone encounters must include all the same components of the service when provided face-to-face. Providers must not make telephone contacts at the exclusion of face-to-face visits.

(8) The following services may be Medicaid-covered services according to an OHP client's benefit package as a stand-alone service; however, when furnished as a stand-alone service, are not reimbursable:

(a) Case management services for coordinating care for a client;

(b) Sign language and oral interpreter services;

(c) Supportive rehabilitation services including, but not limited to, environmental intervention, supported employment, or skills training and activity therapy to promote community integration and job readiness.

(9) AI/AN providers may provide certain services, items and supplies that are prohibited from being billed under the health centers provider enrollment and that require separate enrollment (see OAR 410-146-0021, AI/AN Provider Enrollment). These services include:

(a) Durable medical equipment, prosthetics, orthotics or medical supplies (DMEPOS) (e.g. diabetic supplies) not generally provided during the course of a clinic visit (refer to OAR chapter 410, division 122, DMEPOS);

(b) Prescription pharmaceutical and/or biologicals not generally provided during the clinic visit must be billed to the Division through the pharmacy program (refer to OAR chapter 410, division 121, Pharmaceutical Services);

(c) Targeted case management (TCM) services. For specific information, refer to OAR chapter 410, division 138, TCM.

(10) Client contact with more than one health professional for the same diagnosis or multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. For exceptions to this rule, see OAR 410-146-0086 for reporting multiple encounters.

(11) For claims that require a procedure and diagnosis code the provider must bill as instructed in the appropriate Division program rules and must use the appropriate HIPAA procedure Code Set established according to 45 CFR 162.1000 to 162.1011, which best describes the

specific service or item provided (refer to OARs 410-120-1280, Billing and 410-146-0040, ~~ICD-~~
~~9~~ICD-10-CM Diagnosis Codes and CPT/HCPCs Procedure Codes).

(12) Services furnished by AI/AN enrolled providers that may meet the criteria of a valid encounter (refer to individual program administrative rules for service limitations.):

(a) Medical (OAR chapter 410, division 130);

(b) Diagnostic: The Division covers reasonable services for diagnosing conditions, including the initial diagnosis of a condition that is below the funding line on the Oregon Health Services Commission's Prioritized List of Health Services. Once a diagnosis is established for a service, treatment or item that falls below the funding line, the Division will not cover any other services related to the diagnosis;

(c) Tobacco Cessation (OAR 410-130-0190);

(d) Dental (OAR 410-146-0380 and OAR chapter 410, division 123);

(e) Vision (OAR chapter 410, division 140);

(f) Physical Therapy (OAR chapter 410, division 131);

(g) Occupational Therapy (OAR chapter 410, division 131);

(h) Podiatry (OAR chapter 410, division 130);

(i) Mental Health (refer to the Division of Addiction and Mental Health (AMH) for appropriate OARs);

(j) Alcohol, Chemical Dependency, and Addiction services (OAR 410-146-0021). Requires a letter or licensure of approval by AMH (refer to AMH for appropriate OARs);

(k) Maternity Case Management (OAR 410-146-0120);

(l) Speech (OAR 410 Division 129);

(m) Hearing (OAR 410 Division 129);

(n) The Division considers a home visit for assessment, diagnosis, treatment or maternity case management (MCM) as an encounter. The Division does not consider home visits for MCM as home health services;

(o) Professional services provided in a hospital setting;

(p) Other Title XIX or XXI services as allowed under Oregon's Medicaid State Plan Amendment and the Division's administrative rules.

(13) The following practitioners are recognized by the Division:

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Licensed physician assistants;

(c) Nurse practitioners;

(d) Registered nurses — may accept and implement orders within the scope of their license for client care and treatment under the supervision of a licensed health care professional recognized by the Division in this section and who is authorized to independently diagnose and treat according to appropriate State of Oregon’s Board of Nursing OARs;

(e) Nurse midwives;

(f) Dentists;

(g) Dental hygienists who hold a Limited Access Permit (LAP) — may provide dental hygiene services without the supervision of a dentist in certain settings. For more information, refer to the section on Limited Access Permits in Oregon Revised Statute (ORS) 680.200 and the appropriate Oregon Board of Dentistry OARs;

(h) Pharmacists;

(i) Psychiatrists;

(j) Licensed Clinical Social Workers;

(k) Clinical psychologists;

(l) Acupuncturists — refer to OAR chapter 410, division 130 for service coverage and limitations;

(m) Licensed professional counselor;

(n) Licensed marriage and family therapist; and

(o) Other health care professionals providing services within their scope of practice and working under the supervision requirements of:

(A) Their individual provider’s certification or license; or

(B) A clinic’s mental health certification or alcohol and other drug program approval or licensure by AMH (see OAR 410-146-0021).

(14) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (including drugs and biologicals) furnished on a part-time or intermittent basis to home-bound AI/AN clients residing on tribal land and any other ambulatory services covered by the Division are also reimbursable as permitted within the clinic's scope of services (see OAR 410-146-0080).

(15) The Division reimburses the following services fee-for-service outside of the IHS all-inclusive encounter rate and according to the physician fee schedule:

(a) Laboratory and/or radiology services;

(b) Contraception supplies and medications (see OAR 410-146-0200, Pharmacy);

(c) Administrative medical examinations and report services (refer to OAR chapter 410, division 150);

(d) Death with Dignity services (refer to OAR 410-130-0670); and

(e) Comprehensive environmental lead investigation (refer to OAR 410-130-0245, Early and Periodic Screening, Diagnostic and Treatment Program).

(16) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Division will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before billing the Division (refer to OAR 410-120-1140, Verification of Eligibility).

(17) When a provider receives a payment from any source prior to the submission of a claim to the Division, the amount of the payment must be shown as a credit on the claim in the appropriate field (refer to OARs 410-120-1280, Billing and 410-120-1340, Payment).

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

**DIVISION 147
FQHC AND RHC SERVICES**

410-147-0040

~~ICD-9~~ICD-10-CM Diagnosis and CPT/HCPCs Procedure Codes

(1) The appropriate ~~ICD-9~~ICD-10-CM diagnosis code or codes from 001.0 through V99.9 must be used to identify:

(a) Diagnoses;

(b) Symptoms;

(c) Conditions;

(d) Problems;

(e) Complaints; or

(f) Other reasons for the encounter/visit.

(2) The Division of Medical Assistance Program (DMAP) requires diagnosis codes on all claims, including those submitted by independent laboratories and portable radiology, including nuclear medicine and diagnostic ultrasound providers. A clinic must always provide the client's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(3) Clinics must list the principal diagnosis in the first position on the claim. Use the principal diagnosis code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Clinics may list up to three additional diagnosis codes on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect client care, treatment, or management.

(4) Clinics must list the diagnosis codes using the highest degree of specificity available in the ~~ICD-9~~ICD-10-CM. Use a three-digit diagnosis code only if the diagnosis code is not further subdivided. Whenever fourth-digit or fifth-digit subcategories are provided, the provider must report the diagnosis at that specificity. DMAP considers a diagnosis code invalid if it has not been coded to its highest specificity.

(5) DMAP requires providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards in effect for the date the service(s) was provided:

(a) For dental services, use codes that are in effect for the date the service(s) was provided that are found in Dental Procedures and Nomenclature as maintained and distributed by the American Dental Association for dental services;

(b) For health care services, use the combination of Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes in effect for the date the service(s) was provided. These services include, but are not limited to, the following:

- (A) Physician services;
- (B) Physical and occupational therapy services;
- (C) Radiology procedures;
- (D) Clinical laboratory tests;
- (E) Other medical diagnostic procedures;
- (F) Hearing and vision services.

(6) DMAP maintains unique coding and claim submission requirements for Administrative Exams and Death with Dignity services. Refer to OAR 410 division 150, Administrative Examination and Billing Services, and 410-130-0670, Death with Dignity Services, for specific requirements.

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

410-147-0120

Division Encounter and Recognized Practitioners

(1) The Division of Medical Assistance Programs (Division) reimburses Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services according to the Prospective Payment System (PPS) as follows:

(a) When the service(s) meet the criteria of a valid encounter as defined in Sections (2) through (4) of this rule;

(b) Reimbursement is limited to the Division's Medicaid-covered services according to a client's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act. Other services that are not defined in this rule or the State Plan under Title XIX or Title XXI of the Social Security Act are not reimbursed by the Division.

(2) For the provision of services defined in Titles XIX and XXI and provided through an FQHC or RHC, an "encounter" is defined as a face-to-face or telephone contact between a health care professional and an eligible OHP client within a 24-hour period ending at midnight, as documented in the client's medical record. Section (4) of this rule outlines limitations for telephone contacts that qualify as encounters.

(3) An encounter includes all services, items and supplies provided to a client during the course of an office visit (except as excluded in Sections (6) and (12) of this rule) and those services considered "incident-to." These services are inclusive of the visit with the core

provider meeting the criteria a valid encounter and reimbursed at the PPS all-inclusive encounter rate. These services include:

(a) Drugs or medication treatments provided during a clinic visit are inclusive of the encounter, with the exception of contraception supplies and medications as costs for these items are excluded from the PPS encounter rate calculation (see OAR 410-147-0280 Drugs and OAR 410-147-0480 Cost Statement (DMAP 3027) Instructions);

(b) Medical supplies, equipment, or other disposable products (e.g. gauze, band-aids, wrist brace) are inclusive of an office visit;

(c) Laboratory and/or radiology services (even if performed on another day);

(d) Venipuncture for lab tests. The Division does not deem a visit for lab test only to be a clinic encounter;

(4) Telephone encounters only qualify as a valid encounter for services provided in accordance with OAR 410-130-0595, Maternity Case Management (MCM) and 410-130-0190, Tobacco Cessation (see also OAR 410-120-1200). Telephone encounters must include all the same components of the service when provided face-to-face. Providers must not make telephone contacts at the exclusion of face-to-face visits.

(5) Extended care services furnished under a contract between a county Community Mental Health Program (CMHP) of the FQHC and Addictions and Mental Health Division (AMH) are reimbursed outside of the PPS. Extended care services are those services provided under AMH's licensure requirements and reimbursed under AMH's terms and conditions.

(6) Some Division Medicaid-covered services are not reimbursable when furnished according to Oregon Health Plan (OHP) client's benefit package as a stand alone service. Although costs incurred for furnishing these services are inclusive of the PPS all-inclusive rate calculation, visits where these services were furnished as a stand-alone service were excluded from the denominator for the PPS rate calculation (see OAR 410-147-0480, Cost Statement (DMAP 3027) Instructions). The following services when furnished as a stand-alone service are not reimbursable:

~~(a) Case management services, including case management by a Primary Care Manager (PCM) as defined in OHP administrative rules (OAR 410-141-0700) and previously provided under a PCM contract;~~

~~(ab) Sign language and oral interpreter services;~~

~~(bc) Supportive rehabilitation services including, but not limited to, environmental intervention, supported housing and employment, or skills training and activity therapy to promote community integration and job.~~

(7) FQHCs and RHCs may provide certain services, items and supplies that are prohibited from being billed under the health centers provider enrollment, and requires separate enrollment (see OAR 410-147-0320(1) (b) Federally Qualified Health Center (FQHC)/Rural Health Clinics (RHC) Enrollment). These services include:

(a) Durable medical equipment, prosthetics, orthotics or medical supplies (DMEPOS) (e.g. diabetic supplies) not generally provided during the course of a clinic visit (refer to OAR chapter 410, division 122, DMEPOS);

(b) Prescription pharmaceutical and/or biologicals not generally provided during the clinic visit must be billed to DMAP through the pharmacy program (refer to OAR chapter 410, division 121, Pharmaceutical Services);

(c) Targeted case management (TCM) services (refer to OAR chapter 410, division 138).

(8) Client contact with more than one health professional for the same diagnosis or multiple encounters with the same health professional that take place on the same day and at a single location constitute a single encounter. For exceptions to this rule, see OAR 410-147-0140 for reporting multiple encounters.

(9) Providers are advised to include all services that can appropriately be reported using a procedure code on the claim and bill as instructed in the appropriate Division program rules and must use the appropriate HIPAA procedure code set such as CPT, HCPCS, ~~ICD-9~~ICD-10-CM, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided. For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the client's condition and the service(s) provided. Providers must use the ~~ICD-9~~ICD-10-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual provider rules (refer to OAR 410-120-1280 Billing and see OAR 410-147-0040 ~~ICD-9~~ICD-10-CM Diagnosis and CPT/HCPCS Procedure Codes).

(10) FQHC and RHC services that may meet the criteria of a valid encounter are (refer to individual program administrative rules for service limitations.):

(a) Medical (OAR chapter 410, division 130);

(b) Diagnostic: The Division covers reasonable services for diagnosing conditions, including the initial diagnosis of a condition that is below the funding line on the Prioritized List of Health Services. Once a diagnosis is established for a service, treatment or item that falls below the funding line, the Division will not cover any other services related to the diagnosis;

(c) Tobacco Cessation (OAR 410-130-0190);

(d) Dental (see to OAR 410-147-0125, and refer to OAR chapter 410, division 123);

(e) Vision (OAR chapter 410, division 140);

(f) Physical Therapy (OAR chapter 410, division 131);

(g) Occupational Therapy (OAR chapter 410, division 131);

(h) Podiatry (OAR chapter 410, division 130);

(i) Mental Health (Refer to the Division of Addiction and Mental Health (AMH) for appropriate OARs);

(j) Alcohol, Chemical Dependency, and Addiction services (see also OAR 410-147-0320). Requires a letter or licensure of approval by AMH (refer to AMH for appropriate OARs);

(k) Maternity Case Management (MCM) (OAR 410-147-0200);

(l) Speech (OAR chapter 410, division 129);

(m) Hearing (OAR chapter 410, division 129);

(n) The Division considers a home visit for assessment, diagnosis, treatment or MCM as an encounter. The Division does not consider home visits for MCM as home health services;

(o) Professional services provided in a hospital setting; and

(p) Other Title XIX or XXI services as allowed under Oregon's Medicaid State Plan Amendment and the Division's administrative rules.

(11) The following practitioners are recognized by the Division:

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Licensed Physician Assistants;

(c) Dentists;

(d) Dental Hygienists who hold a Limited Access Permit (LAP) — may provide dental hygiene services without the supervision of a dentist in certain settings. For more information, refer to the section on Limited Access Permits, ORS 680.200 and the appropriate Oregon Board of Dentistry OARs;

(e) Pharmacists;

(f) Nurse Practitioners;

(g) Nurse Midwives;

(h) Other specialized nurse practitioners;

(i) Registered nurses — may accept and implement orders within the scope of their license for client care and treatment under the supervision of a licensed health care professional recognized by the Division in this section and who is authorized to independently diagnose and treat according to appropriate State of Oregon's Board of Nursing OARs;

(j) Psychiatrists;

(k) Licensed Clinical Social Workers;

(l) Clinical psychologists;

(m) Acupuncturists — Refer to OAR chapter 410, division 130 for service coverage and limitations;

(n) Licensed professional counselor;

(o) Licensed marriage and family therapist; or

(p) Other health care professionals providing services within their scope of practice and working under the supervision requirements of:

(A) Their individual provider's certification or license; or

(B) A clinic's mental health certification or alcohol and other drug program approval or licensure by the Addictions and Mental Health Division (AMH) (see OAR 410-147-0320).

(12) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound clients (limited to areas in which the Secretary has determined that there is a shortage of home health agencies — Code of Federal Regulations 42 § 405.2417), and any other ambulatory services covered by the Division are also reimbursable as permitted within the clinic's scope of services (see OAR 410-147-0020).

(13) FQHCs and RHCs may furnish services that are reimbursed outside of the PPS all-inclusive encounter rate and according to the physician fee schedule. These services include:

(a) Administrative medical examinations and report services (refer to OAR chapter 410, division 150);

(b) Death with Dignity services (refer to OAR 410-130-0670);

(c) Services provided to Citizen/Alien-Waived Emergency Medical (CAWEM) clients (refer to OARs 410-120-1210, 461-135-1070 and 410-130-0240);

(d) Services provided to Qualified Medicare Beneficiary (QMB) only clients (refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System). Specific billing information is located in the FQHC and RHC Supplemental Information billing guide; and

(e) Comprehensive environmental lead investigation (refer to OAR 410-130-0245, Early and Periodic Screening, Diagnostic and Treatment Program).

(14) OHP benefit packages and delivery system are described in OAR 410-120-1210. Most OHP clients have prepaid health services, contracted for by the Authority through enrollment in a Prepaid Health Plan (PHP). Non-PHP-enrolled clients, receive services on an "open card" or "fee-for-service" (FFS) basis.

(a) The Division is responsible for making payment for services provided to open card clients. The provider will bill the Division the clinic's encounter rate for Medicaid-covered services

provided to these clients according to their OHP benefit package (see OAR 410-147-0360, Encounter Rate Determination).

(b) A PHP is responsible to provide, arrange and make reimbursement arrangements for covered services for their Division members (refer to OAR 410-120-0250, and OAR chapter 410, division 141, OHP administrative rules governing PHPs). The provider must bill the PHP directly for services provided to an enrolled client (See also OARs 410-147-0080, Prepaid Health Plans, and 410-147-0460, PHP Supplemental Payment). Clinics must not bill the Division for PHP-covered services provided to eligible OHP clients enrolled in PHPs. Exceptions include:

(A) Family planning services provided to a PHP-enrolled client when the clinic does not have a contract with the PHP, and if the PHP denies payment (see OAR 410-147-0060); and

(B) HIV/AIDS prevention provided to a PHP-enrolled client when the clinic does not have a contract with the PHP, and if the PHP denies payment (see OAR 410-147-0060).

(15) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Division will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before billing the Division (refer to OAR 410-120-1140 Verification of Eligibility).

(16) When a provider receives a payment from any source prior to the submission of a claim to the Division, the amount of the payment must be shown as a credit on the claim in the appropriate field (refer to OARs 410-120-1280 Billing and 410-120-1340 Payment).

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-147-0500

Total Encounters for Cost Reports

(1) Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHCs) are required to report the total number of encounters for furnishing services outlined in 42 USC 1396d(a)(2)(C) and 1396d(a)(2)(B), respectively.

(2) In general, the Division of Medical Assistance Programs (DMAP) calculates a FQHC or RHC's Prospective Payment System (PPS) encounter rate by dividing the total costs incurred by a clinic for furnishing services as defined in 42 USC 1396d(a)(2)(B) or (C) by the total number of all clinic visits, or "encounters." The intent of PPS is to calculate the average cost of an encounter, and not the average cost of a Medicaid billable encounter.

(3) This rule provides guidance for cost reporting of all encounters. It is the responsibility of the FQHC and RHC to report all encounters, except when expressly directed not to elsewhere in this rule. FQHCs and RHCs are required to include ALL:

(a) Encounters for all clients regardless of payor;

(b) Encounters for FQHC or RHC services that are not covered by Medicaid, Medicare, Third Party Payor or other party, but otherwise have an associated cost for providing the service

whether billed to the client (e.g. uninsured, signed waiver on file) or absorbed by the clinic;
and;

(c) Encounters regardless of line placement on the Health Services Commission's Prioritized List of Health Services. For the purpose of reporting encounters according to this rule, encounters are not subject to the HSC Prioritized List, or service limitations and benefit reductions implemented by the Division of Medical Assistance Programs (DMAP).

(4) FQHCs and RHCs must report all encounters furnished to all client populations irrespective of coverage or payor source. Examples of client populations include, but are not limited to:

(a) Oregon Health Plan (OHP) clients (includes both fee-for-service and prepaid health plan (PHP) clients). Refer to OAR 410-147-0120 for more information regarding OHP encounters;

(b) Citizen/Alien-Waived Emergency Medical (CAWEM) clients. Refer also to OAR 410-120-1210(3)(f).

(c) Family Planning Expansion Program (FPEP) Title X, clients;

(d) Uninsured and/or self-pay clients;

(e) Medicare clients;

(f) Third party or private pay insurance clients;

(g) County- and/or clinic-pay clients (services paid or funded by the county or clinic); and

(h) Clients funded by federal, state, local or other grants.

(5) FQHCs and RHCs must exclude from the total number of reported encounters:

(a) Encounters attributed to non-allowable costs:

(A) Services performed under the auspices of a Women, Infant and Children (WIC) program or a WIC contract;

(B) Services performed and reimbursed under separate enrollment. e.g. Targeted Case Management;

(C) Services provided by patient advocates/ombudsmen and Outstationed Outreach Workers, employed by or under contract with the FQHC or RHC, for the primary purpose of providing outreach and/or group education sessions;

(D) Provider participation in a community meeting or group session that is not designed to provide clinical services. This includes, and is not limited to, information sessions for prospective Medicaid beneficiaries, and information presentations about available health services at the FQHC or RHC; and

(E) Health services provided as part of a large-scale "free to the public" or "nominal fee" effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair);

(b) Encounters for specific services outlined in 42 USC 1396d(a)(2)(B) and (C), that do not meet the criteria of a valid encounter when furnished as a stand-alone service. Costs for furnishing these services is an allowed administrative program cost and should be reported on a clinic's cost statement for calculating a clinic's PPS encounter rate. Refer to OAR 410-147-0480, Costs Statement (DMAP 3027) Instructions. Examples include, but are not limited to:

(A) Case management services for coordinating health care for a client;

(B) Enabling services, including but not limited to, sign language and oral interpreter services;

(C) Supportive, rehabilitation services including, but not limited to, environmental intervention, and supported housing and employment; skills training and activity therapy to promote community integration and job readiness;

(D) Laboratory and radiology services, including venipuncture and tuberculosis (TB) tests (the initial visit for the TB test administered to the epidermis);

(E) Prescription refills; and

(F) Services provided without the client present, except for telephone contacts as specified in this rule section (6)(c).

(6) FQHCs and RHCs are required to include encounters for services furnished by practitioners recognized by DMAP in OAR 410-147-0120(6). Examples of encounters that may be overlooked but should be included are:

(a) Encounters below the funding line on the Health Services Commission's Prioritized List of Health Services. All encounters are to be reported regardless of line placement;

(b) Encounters outside of the clinic by primary care practitioners (e.g. services furnished in a hospital or residential treatment setting);

(c) Telephone contacts as provided for in the Tobacco Cessation, OAR 410-130-0190; and Maternity Case Management (MCM), 410-130-0595, programs. See also 410-120-1200(2)(y);

(d) Medication management-only encounters by a behavioral health practitioner;

(e) Encounters by Registered and Licensed Practical Nurses:

(A) Home encounters in an area in which the Secretary of the Health Resources and Services Administration, Health and Human Services, has determined that there is a shortage of home health agencies (OAR 410-147-0120(10));

(B) Administration of immunizations/vaccinations encounters;

(C) "99211" encounters; and

(D) Maternity Case Management (MCM) encounters.

(7) Global procedures require attention for accurate reporting of encounters:

(a) Obstetrics procedures: Each antepartum, delivery and postpartum encounter included in a global procedure for maternity and delivery services should be reported as a separate encounter;

(b) Dental procedures: Multiple contacts for global dental procedures should be reported as a single encounter. Refer to OAR 410-147-0040(5), ~~ICD-9~~ICD-10-CM Diagnosis and CPT/HCPCs Procedure Codes, for more information;

(c) Surgical procedures: Refer to OAR 410-147-0040(5), ~~ICD-9~~ICD-10-CM Diagnosis and CPT/HCPCs Procedure Codes, for more information:

(A) Services within a surgical package and "included" in a given CPT surgical code are reported as a single encounter. Refer to OAR 410-130-0380, Surgical Guidelines, for more information; and

(B) The initial consultation or evaluation of the problem by the provider to determine the need for surgery, and separate from a preoperative appointment, is a separate encounter.

(8) A surgical procedure furnished to an OHP client and provided by more than one surgeon employed by the FQHC or RHC does not count as multiple encounters. The exception to this rule is major surgery, including a cesarean delivery, furnished to a CAWEM client. Services provided by the primary surgeon and the assistant surgeon, when both are employed with the FQHC or RHC, may be eligible as multiple encounters if medically necessary.

(9) When two or more services are provided on the same date of service:

(a) With distinctly different diagnoses, a clinic should report multiple encounters when the criteria in OAR 410-147-0140, Multiple Encounters, is met; or

(b) With similar diagnoses, a clinic must report one encounter.

(10) Clinics must maintain, for no less than five years, all documentation relied upon by the clinic to calculate the number of encounters reported on the cost statement (DMAP 3027):

(a) All documentation supporting the number of encounters reported on the cost statement must be sufficient to withstand an audit; and

(b) The total number of encounters calculated from all sources of documentation must reconcile to the total number of encounters reported on the cost statement, and subtotaled encounters must reconcile to each documentation source relied upon.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

DIVISION 148
HOME ENTERAL/PARENTERAL NUTRITION AND IV SERVICES

410-148-0020

Home Enteral/Parenteral Nutrition and IV Services

(1) The Division of Medical Assistance Programs (Division) will make payment for medically appropriate goods, supplies and services for home enteral/parenteral nutrition and IV therapy on written order or prescription. (a) The order or prescription must be dated and signed by a licensed prescribing practitioner, legible and specify the service required, the ~~ICD-9~~ICD-10-CM diagnosis codes, number of units and length of time needed.

(b) The prescription or written physician order for solutions and medications must be retained on file by the provider of service for the period of time specified in the Division's General Rules.

(c) An annual assessment and a new prescription are required once a year for ongoing services.

(d) Also covered are services for subcutaneous, epidural and intrathecal injections requiring pump or gravity delivery.

(2) All claims for enteral/parenteral nutrition and IV services require a valid ~~ICD-9~~ICD-10-CM diagnosis code. It is the provider's responsibility to obtain the actual diagnosis code(s) from the prescribing practitioner. Reimbursement will be made according to covered services on funded lines of the Health Services Commission's Prioritized List of Health Services, and these rules.

(3) The Division requires one initial nursing service visit to assess the home environment and appropriateness of enteral/parenteral nutrition or IV services in the home setting and to establish the client's treatment plan.

(a) This nursing service visit for assessment purposes does not require payment authorization.

(b) The nursing service assessment visit is not required when:

(A) The only service provided is oral nutritional supplementation;

(B) The services are performed in an Ambulatory Infusion Suite of the home infusion therapy provider.

(4) Nursing service visits specific to this Home Enteral/Parenteral and IV services program are provided in the home, or an Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS) and will be reimbursed by the Division only when prior authorized, and performed by a person who is licensed by the Oregon State Board of Nursing to practice as a Registered Nurse. All registered nurse delegated or assigned nursing care tasks must comply with the Oregon State Board of Nursing, Nurse Practitioner Act and Administrative Rules regulating the practice of nursing.

(5) Payment for services identified in the Home Enteral/Parenteral Nutrition and IV Services provider rules will be made only when provided in the client's place of residence (i.e., home or nursing facility) or an Ambulatory Infusion Suite (AIS).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065