Medical-Surgical Services Provider Guide

Use this guide as a supplement to the Medical-Surgical Services Oregon Administrative Rules (Chapter 410 Division 130). See current Medical-Surgical Services rules for official policies regarding billing.

Contents (last updated August 31, 2015)

Client eligibility and enrollment 1
Prior authorization 2
Primary Care Management Services 2
- Primary Care Manager (PCM) 2
- Capacity 3
- New patients 3
- Providing medically appropriate care 3
- Emergency care 3
- Substituting for a PCM 3
- Referrals 4
- Referral and authorization exemptions 4
- Claims submitted by PCMs 5

Billing for medical-surgical services 5
- Where to find codes 5
- Modifiers 5

Claim status and adjustments 5
Hysterectomy Consent 6
Consent to Sterilization forms 6
- Consent to Sterlization form instructions 7

Maternity Case Management forms 8
Lead Risk Assessment Questionnaire 8
Pharmaceutical references 8
Oregon water systems with fluoride 9
- Systems with naturally occurring fluoride 9
- Recommended dietary fluoride supplementation schedule 10

Vaccines for Children program 10

Client eligibility and enrollment

Refer to General Rules and OHP Rules for information about the service coverage according to OHP benefit plans and the Prioritized List of Health Services.

The OHP eligibility verification page explains how to verify eligibility using the Provider Web Portal, Automated Voice Response, or electronic data interchange (EDI) 270/271 transaction.

Prior authorization

The following services require prior authorization (PA):

- Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS – Division 122)
- Home health services (Division 127)
- Home Enteral/Parenteral and IV services (Division 148)
- Hospital dentistry and certain dental services (Division 123)
- Physical and occupational therapy (Division 131)
- Private duty nursing (Division 132)
- Speech and hearing services (Division 129)
- Certain pharmaceutical, medical-surgical, vision, and hospital services

Refer to the program-specific administrative rules and supplemental information for specific details and required forms. Submit prior authorization (PA) requests to DMAP using the Provider Web Portal (instructions) or the MSC 3971 (instructions).

- For OHP managed care plan members, contact the plan for PA instructions.
- For complete instructions on how to submit PA requests to DMAP, see the Prior Authorization Handbook.

Primary Care Management Services

Services provided to ensure Primary Care Management (PCM) members maintain physical and emotional development and health. These services include a comprehensive ongoing assessment of medical needs and the development and implementation of a plan for PCM members to obtain services that are preventive or primary care, and follow-ups, as appropriate.

PCM case managed services include the following:

- Preventive services – See OAR 410-141-0480, and 410-141-0860 of the *OHP (MCO and CCO) Administrative Rules*;
- Primary care services;
- Specialty services;
- Inpatient hospital services;
- Outpatient hospital services except laboratory, X-ray, and maternity management.

Primary Care Manager (PCM)

The PCM provides preventive and primary care services to PCM members for a case management payment. The PCM bills DMAP on a fee-for-service basis. PCMs may be:

- Physicians (MD or DO).
- Nurse practitioners.
- Physician assistants.
- Naturopaths with physician backup.
- Hospital primary care clinics.
- Rural Health Clinics.
- Indian Health Service Clinics.
- Tribal Health Clinics.

Capacity
Each PCM should set capacity based on the number of individuals in the current patient load eligible for the Oregon Health Plan (OHP) and any additional "room" in the practice for new patients under the OHP. Capacity may include many existing Medicaid patients.

The PCM adjusts capacity levels and may open or close enrollment at any time to meet capacity limitations. Enrollment must be restricted to a defined service area (either a county or counties).

New patients
New PCM members are eligible for an initial visit. To bill for an initial visit, use the appropriate "New Patient" code under "Preventive Medicine Services" in the Evaluation and Management Services section of your current CPT manual.

If a new PCM member seeks emergency care and the PCM has not previously examined the patient or obtained prior medical history, the PCM may defer professional judgment and authority to the physician/practitioner treating the emergency.

PCMs are encouraged to establish a relationship with new PCM members.

Providing medically appropriate care
To ensure the availability and accessibility of services to PCM members, PCMs must have:
- Responsive appointment scheduling.
- Office hours and after-hours availability for emergency consultation.
- Reasonable provisions for interpretation to assist patients who do not speak English (when necessary and as available in the community).

Emergency care
PCMs must approve and authorize all emergency room (ER) care. PCMs must have 24-hour-a-day, 7-day-a-week coverage which includes after-hours telephone access for consultation about urgent/emergent care.

If a new PCM member seeks emergency care and the PCM has not previously examined the patient or obtained prior medical history, the PCM may defer professional judgment and authority to the physician/practitioner treating the emergency.

PCMs must provide or arrange for follow-up care as medically appropriate after ER care. When medically appropriate, PCMs must arrange for office or clinic care as an alternative to ER care.

Substituting for a PCM
A substitute care case manager must agree to assume the role for the PCM when the PCM is temporarily absent from practice due to vacation, extended training, illness, etc.

Referrals

Services provided by the following providers require a referral from the PCM:

- Chiropractors
- Migrant and Community Health Clinics
- County Health Departments
- Federally Qualified Health Centers
- Indian Health Service and Tribal Health Clinics
- Medical Physicians
- Nurse Practitioners
- Osteopathic Physicians
- Physician Assistants
- Podiatrists
- Rural Health Clinics
- Naturopaths
- Hospital – Inpatient
- Hospital – Outpatient, other than laboratory, X-ray, or maternity case management

All claims requiring a PCM referral must list the PCM's National Provider Identifier (NPI) in the appropriate box on the claim.

Referral and authorization exemptions

DMAP will pay for the following services without a direct PCM referral:

- Anesthesiology
- Dental care
- Durable medical equipment
- Eye care (routine vision exams, dispensing services, and vision materials)
- Family planning services
- HIV prevention services
- Immunizations and treatment for communicable and sexually transmitted diseases provided by a publicly funded clinic
- Laboratory and X-ray services
- Maternity case management services
- Mental health and chemical dependency services
- Pharmacy services
- Physical and occupational therapy
- School-based services provided under an Individual Education Plan or an Individual Family Service Plan
- Speech and hearing services
- Targeted case management services
- Transportation

Although these services do not require a direct referral, they should be documented in the PCM member's medical record when the PCM makes a direct referral or when reported by the specialty care provider or PCM member. *PCM members should be encouraged to report all medical treatment to their PCM*.

Claims submitted by PCMs
PCMs must submit claims according to DMAP's Administrative Rules for medical services provided. Refer to the appropriate provider guidelines for specific instructions.

DMAP will send a remittance advice showing specific payments and other claims actions. Medical services will be paid at a fee-for-service rate for covered services. The PCM will automatically receive a monthly case management fee from DMAP for each PCM member.

Billing for medical-surgical services

Use the Provider Web Portal professional claim, 837P or CMS-1500.

- **Billing instructions** are available on the OHP provider billing tips page.
- **For information about electronic billing,** go to the Electronic Business Practices Web page.

Where to find codes
See the Medical-Surgical Services rules (OAR 410 Division 130) for specific coding information. Obtain a copy of the current rules online, or call DMAP at 503-945-5772 or 800-527-5772.

Code books for ICD-10-CM, CPT, and HCPCS codes can be purchased from:

American Medical Association
PO Box 10950
Chicago, IL 60610

Phone: 800-621-8335
Web site: www.amapress.com
Or other reputable supplier

Modifiers
DMAP uses national standards for coding and recognizes all national modifiers. Use CPT and HCPCS guidelines for use of modifiers unless otherwise instructed below.

- 99 - DMAP can only accept two 2-digit modifiers per line. For more than 2 modifiers, use modifier 99 in the first position. Place the most pertinent modifier in the next position, followed by all other modifier codes.

Claim status and adjustments

For information about the paper remittance advice and other ways to get claim status information via the Provider Web Portal, AVR or EDI 835 (Electronic Remittance Advice), go to the OHP remittance advice page.

For information about how to adjust a claim, refer to the Claim Adjustment Handbook.

Hysterectomy Consent

Use the DMAP 741 (English or Spanish). Do not use Consent to Sterilization forms (DMAP 742A and DMAP 742B) for hysterectomies. Hysterectomies for the sole purpose of sterilization are not covered.

Mail a copy of the completed form to:

DMAP
PO Box 14958
Salem, OR 97309-4958

See OAR 410-130-0580 for more information about hysterectomy consent procedures.

Consent to Sterilization forms

Use the DMAP 742A (English or Spanish) for clients 21 years of age or older, and the DMAP 742B (English or Spanish) for clients 15 to 20 years of age.

Mail a copy of the completed form to:

DMAP
PO Box 14958
Salem, OR 97309-4958

Make sure the client signs and dates the form 30 days prior to performing sterilization. DMAP will not pay for sterilization when the consent form has not been signed and dated by the client 30 days before the procedure is performed.

See OAR 410-130-0580 for more information about sterilization consent procedures and exceptions.

Consent to Sterilization form instructions

Top of Page 1	
1.	Enter the client's name, sex, and 8-digit Medicaid ID number where indicated.
Page 1: Patient's Statement	
2.	Enter the name of the doctor or clinic.
3.	Enter the name of the surgical procedure.
4.	Enter the client's birth date.
5.	Enter the client's name.
6.	Enter the name of the doctor performing the procedure.
7.	Enter the name of the procedure to be performed.
8.	The client must sign and date the consent.
9.	The client's race and ethnicity designation is optional.
Page 1: Interpreter's Statement – Complete only if an interpreter is required	
10.	Enter the name of the language used to explain the consent to the client.
11.	The interpreter must sign and date the consent.
Page 2: Statement of Person Obtaining Consent	
12.	Enter the client's name.
13.	Enter the name of the procedure to be performed.
14.	The person obtaining the consent must sign and date this statement. The date of signature must be on or after the client's signature date, but before the procedure date.
15.	Enter the name and full address of the physician or facility.
Page 2: Physician's Statement	
16.	Enter the client's name.
17.	Enter the date the procedure was performed.
18.	Enter the name of the procedure to be performed.
19.	**Alternative final paragraphs:** Use paragraph 1 in most cases; use paragraph 2 in the case of premature delivery or emergency abdominal surgery where the procedure occurs less than 30 days after the client's signature date. Cross out the paragraph you do not use. When using paragraph 2, check the appropriate box. ■ If the first box is checked, enter the client's expected date of delivery. ■ If the second box is checked, describe the circumstances requiring surgery.
20.	The performing physician must sign this consent. The date of signature must be either the date the sterilization was performed or a date following the sterilization.

Maternity Case Management forms

Providers must complete the following forms to meet minimum documentation requirements for Maternity Case Management Services. See OAR 410-130-0595 for more information on Maternity Case Management.

- DMAP 2470 - Initial Assessment and Client Service Plan
- DMAP 2471 - Training and Education Tracking
- DMAP 2472 - Home / Environmental Assessment
- DMAP 2473 - Five A's Intervention Record for Smoking Cessation

Lead Risk Assessment Questionnaire

Providers must complete the DMAP 9033 for all children ages 12 to 72 months as part of the Early and Periodic Screening Diagnostic and Treatment (EPSDT) program. For more information, instructions and tables relating to EPSDT, see OAR 410-130-0245.

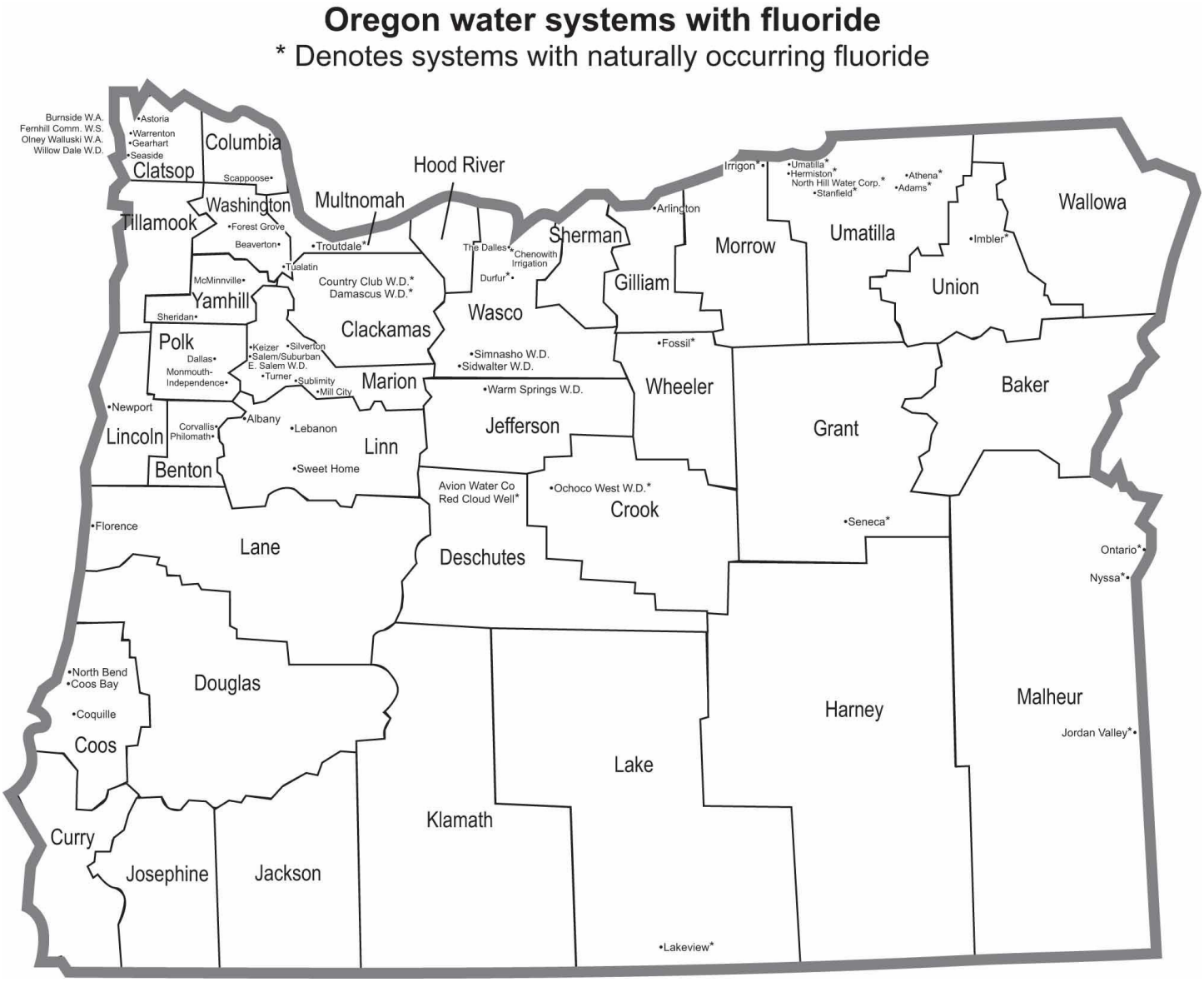
Pharmaceutical references

Referenced OARs are from the Pharmaceutical Services rules (OAR 410 Division 121) unless otherwise noted.

- **Drug Use Review (DUR):** See OAR 410-121-0100.
- **Prescription requirements (for fee-for-service clients only):** Follow criteria outlined in OAR 410-121-0145.
- **Preferred Drug List:** Part of the PMPDP, the Preferred Drug List (PDL) is a tool to identify the most cost-effective drugs for open-card OHP patients. New prescriptions for non-preferred physical health drugs require prior authorization. For more information, see The OHP Preferred List (PDL).
- **Pharmaceutical reimbursement:** See OAR 410-121-0155. For physician-administered drugs, Clozapine therapy supervision and billing, see OAR 410-130-0180 (Medical-Surgical Services).
- **Medicaid Drug Rebate Program:** See OAR 410-121-0157. This federal program requires drug manufacturers to enter into an agreement with CMS to provide rebates to DMAP on all their drug products. DMAP will only reimburse providers for drug products that are manufactured or labeled by companies who participate in the program. For a list of participating drug manufacturers, see the CMS website.
- **Medication Therapy Management Service Claims (MTMS):** DMAP will reimburse pharmacies for Medication Therapy Management Services (MTMS) provided by pharmacists. Services must be provided based on referral from a physician, licensed provider, or a Prepaid Health Plan (PHP). For documentation requirements, refer to Guideline Note 64 of the Prioritized List of Health Services. For specific information on when to bill for MTMS, refer to CPT coding guidelines.

Oregon water systems with fluoride

This map shows communities and water districts with water supplies that have naturally occurring fluoride or adjusted fluoride.



Systems with naturally occurring fluoride

Over time or seasonally, these systems can show variations of up to 0.5 parts per million (ppm). To obtain the most current level, contact the water system directly.

Name	Phone	County
Country Club Water District	503-622-5374	Clackamas
Damascus Water District	503-658-5585	Clackamas
Ochoco West Water District	541-447-5612	Crook
Avion Water Co. Red Cloud Well	541-382-5342	Deschutes
Arlington	541-454-2743	Gilliam
Seneca	541-542-2161	Grant

Name	Phone	County
Lakeview	541-947-2371	Lake
Jordan Valley	541-586-2460	Malheur
Nyssa	541-372-2264	Malheur
Ontario	541-889-8011	Malheur
Irrigon	541-922-3047	Morrow
Troutdale (1/3 of system)	503-661-5165	Multnomah
Adams	541-566-3841	Umatilla
Athena	541-566-3862	Umatilla
Hermiston	541-567-5221	Umatilla
North Hill Water Corporation	541-567-6764	Umatilla
Stanfield	541-449-3831	Umatilla
Umatilla	541-922-3226	Umatilla
Imbler, City of	541-531-6095	Union
Chenowith Water People's Utility District	541-296-8027	Wasco
Dufur	541-467-2401	Wasco
Fossil	541-763-2698	Wheeler

Drinking Water Program, PO Box 14450, Portland OR 97214-0450; 971-673-0405

Recommended dietary fluoride supplementation schedule

Age	Less than 0.3 ppm F	0.3 - 0.6 ppm F	More than 0.6 ppm F
Birth – 6 mos.	0	0	0
6 mos. – 3 yrs.	0.25 mg/day	0	0
3 yrs. – 6 yrs.	0.50 mg/day	0.25 mg/day	0
6 yrs. up to at least 16 yrs.	1.00 mg/day	0.50 mg/day	0

American Academy of Pediatric Dentistry, Special Issue: Reference Manual 1997-1998, Volume 19, Number 7.

Vaccines for Children program

The Vaccines for Children program (VFC) supplies federally purchased free vaccines for immunizing eligible children in public and private practices - at no cost to participating private health care providers.

- Patients through age 18 are eligible if they are enrolled in Medicaid or are uninsured; or American Indian/Alaskan Native.
- For more information, go to the VFC website.
- To enroll in the VFC program, call 971-673-0300 and request a "VFC Recruitment Packet."