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TEMPORARY ADMINISTRATIVE RULES

Oregon Health Authority, Division of Medical Assistance Programs	410
Agency and Division	Administrative Rules Chapter Number
Sandy Cafourek	sandy.c.cafourek@state.or.us
Rules Coordinator	Email Address
500 Summer St. NE, Salem, OR 97301	503-945-6430
Address	Telephone
Upon filing.	
Adopted on	
01/01/2014 thru 06/30/2014	
Effective dates	

RULE CAPTION

Elimination of Oregon Health Plan standard benefit plan effective January 1, 2014
Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND:

410-120-0030, 410-120-1210, 410-120-1230, 410-123-1060, 410-123-1200, 410-123-1260, 410-123-1540, 410-125-0020, 410-125-0080, 410-125-0085, 410-130-0240, 410-131-0120, 410-138-0000, 410-138-0007, 410-138-0009, 410-141-0860, 410-142-0040

SUSPEND:

410-122-0055, 410-123-1670, 410-125-0047, 410-127-0050, 410-129-0195, 410-130-0163, 410-132-0055, 410-146-0022, 410-146-0380, 410-147-0125, 410-148-0090

Stat. Auth.: ORS 413.042, 414.065

Other Auth.:

Stats. Implemented: ORS 414.025, 414.065, 414.329, 414.706, 414.707, 414.708, 414.710 & 688.135

RULE SUMMARY

The Affordable Care Act (ACA) set forth a series of changes for Medicaid and CHIP eligibility including the expansion to the new adult category. This adult group includes the adults that were known as the OHP standard population. Effective

January 1, 2014, the current OHP Standard benefit package will be eliminated, and those clients receiving this benefit package will receive the OHP Plus benefit. Additionally, the ACA added new exemptions to copayments; all changes are pending approval by the Centers for Medicare and Medicaid services (CMS). The Authority needs to amend and repeal these rules to be in compliance with the ACA. Other non-substantive changes include moving the CAWEM Plus benefit description from OAR 410-120-0030 to 410-120-1210, correcting or clarifying grammatical or wording revisions, acronyms and OAR references.

STATEMENT OF NEED AND JUSTIFICATION

The temporary amendment of OAR 410-120-0030, 410-120-1210, 410-120-1230, 410-123-1060, 410-123-1200, 410-123-1260, 410-123-1540, 410-125-0020, 410-125-0080, 410-125-0085, 410-130-0240, 410-131-0120, 410-138-0000, 410-138-0007, 410-138-0009, 410-141-0860, 410-142-0040

The repeal of OAR 410-122-0055, 410-123-1670, 410-125-0047, 410-127-0050, 410-129-0195, 410-130-0163, 410-132-0055, 410-146-0022, 410-146-0380, 410-147-0125, and 410-148-0090.

In the Matter of

Federal register, Vol. 77, No.57 published March 23, 2012 and Federal register, Vol. 78, No.135 published July 15, 2013
<http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf> and
<http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf>

Documents Relied Upon, and where they are available

The Affordable Care Act (ACA) set forth a series of changes for Medicaid and CHIP eligibility including the expansion to the new adult category. This adult group includes the adults that were known as the OHP standard population. Effective January 1, 2014, the current OHP Standard benefit package will be eliminated, and those clients receiving this benefit package will receive the OHP Plus benefit. Additionally, the ACA added new exemptions to copayments; all changes are pending approval by the Centers for Medicare and Medicaid services (CMS). The Authority needs to amend and repeal these rules to be in compliance with the ACA. Other non-substantive changes include moving the CAWEM Plus benefit description from OAR 410-120-0030 to 410-120-1210, correcting or clarifying grammatical or wording revisions, acronyms and OAR references.

Need for the Temporary Rule(s)

The Authority needs to amend and repeal these rules to be in compliance with the ACA. Other non-substantive changes include moving the CAWEM Plus benefit description from OAR 410-120-0030 to 410-120-1210, correcting or clarifying grammatical or wording revisions, acronyms and OAR references. The Authority finds that failure to act promptly will result in serious prejudice to the public interest, providers, the Authority, and recipients of OHP standard benefits. These rules need to be adopted promptly so that providers, OHP recipients and clients applying for medical assistance understand that the OHP standard benefit plan is eliminated effective January 1, 2014.

Judy Mohr Peterson *Judy Mohr Peterson* *12/31/2013*
Authorized Signer Printed Name Date

Authorization Page replaces the ink signature on paper filings. Have your authorized signer sign and date, then scan and attach it to your filing. You must complete this step before submitting your Permanent and Temporary filings.

410-120-0030 - Children's Health Insurance Program

(1) The Children's Health Insurance Program (CHIP) is a federal non-entitlement program. The Oregon Health Authority (Authority), Division of Medical Assistance Program (Division) administers two programs funded under CHIP in accordance with the Oregon Health Plan (OHP) waiver and the CHIP state plan.

(a) CHIP: Provides health coverage for uninsured, low-income children who are ineligible for Medicaid;

(b) CHIP Pre-natal care expansion program.

(2) The General Rules Program (OAR 410-120-0000 et. seq.) and the Oregon Health Plan OHP Program rules (OAR 410-141-0000 et. seq.) applicable to the Medicaid program are also applicable to the Authority's CHIP program.

(3) Children under 19 years of age, who meet the income limits, citizenship requirements and eligibility criteria for medical assistance established in OAR chapter 41064 through the program acronym OHP-CHP, receive the OHP Plus benefit package (for benefits refer to OAR 410-120-1210).

~~(4) CHIP Prenatal care expansion coverage: Women not eligible for Medicaid at or below 185% of the FPL, with the benefit package identifier CWX:~~

~~(a) Receive the OHP Plus benefit package with limitations as described in subsection (d) of these rules;~~

~~(b) Effective October 1, 2013 reside in the state during pregnancy.~~

~~(c) The day after pregnancy ends, eligibility for medical services is based on eligibility categories established in OAR chapter 461;~~

~~(d) The following services are not covered for this program:~~

~~(A) Postpartum care (except when provided and billed as part of a global obstetric package code that includes the delivery procedure);~~

~~(B) Sterilization;~~

~~(C) Abortion;~~

~~(D) Death with dignity services;~~

~~(E) Hospice.~~

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-120-1210 - Medical Assistance Benefit Packages and Delivery System

(1) The services clients are eligible to receive are based upon their benefit package, ~~for which they are eligible.~~ Not all packages receive the same benefits.

(2) The Division of Medical Assistance Programs (Division) benefit package description, codes, eligibility criteria, coverage, limitations and exclusions are identified in these rules.

(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in any ~~each of the~~ Division chapter 410 OARs.

(4) Benefit package descriptions:

(a) Oregon Health Plan (OHP) Plus:

(A) Benefit package identifier: BMH

(B) Eligibility criteria: As defined in federal regulations and in the 1115 OHP waiver demonstration, a client is categorically eligible for medical assistance if he or she is eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria.

(C) Coverage includes:

(i) Services above the funding line on the Health Evidence Review Commission (HERC) Health Services Commission's (HSC) Prioritized List of Health Services (Prioritized List), (OAR 410-141-0480 through 410-141-0520);

(ii) Ancillary services, (OAR 410-141-0480);

(iii) Substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;

(iv) Mental health services based on the ~~HSC~~ Prioritized List of Health Services to be provided through Community Mental Health Programs or their subcontractors;

(v) Hospice;

(vi) Post-hospital extended care benefit, up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043), or by the Fully Capitated Health Plan (FCHP) for clients enrolled in an FCHP;

(vii) Cost sharing (e.g., copayments) may apply to some covered services;

(DB) Limitations: The following services have limited coverage for ~~non~~-non-pregnant adults age 21 and older. (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410, division 123);

(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140);

~~(b) OHP Standard:~~

~~(A) Benefit Package identifier code: KIT;~~

~~(B) Eligibility criteria: Adults and childless couples who are eligible through the 1115 Medicaid expansion waiver and meet Authority-adopted income and other eligibility criteria; the Department identifies these clients through the program acronym, OHP-OPU;~~

~~(C) Coverage includes:~~

~~(i) Services above the funding line on the HSC Prioritized List, (OAR 410-141-0480 through 410-141-0520);~~

~~(ii) Ancillary services, (OAR 410-141-0480);~~

~~(iii) Outpatient substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;~~

~~(iv) Outpatient mental health services based on the HSC Prioritized List of Health Services, to be provided through Community Mental Health Programs or their subcontractors;~~

~~(v) Hospice;~~

~~(vi) Post hospital extended care benefit, up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043) or by the Fully Capitated Health Plan (FCHP) for clients enrolled in an FCHP.~~

~~(B) Limitations: The following services have limited coverage (Refer to the cited OAR chapters and divisions for details):~~

~~(i) Selected dental (OAR chapter 410, division 123);~~

~~(ii) Selected durable medical equipment and medical supplies (OAR chapter 410, division 122 and 130);~~

~~(iii) Selected home enteral/parenteral services (OAR chapter 410, division 148);~~

~~(iv) Other limitations as identified in individual Division program administrative rules.~~

~~(C) Exclusions: The following services are not covered. Refer to the cited OAR chapters and divisions for details:~~

~~(i) Acupuncture services, except when provided for substance use disorder treatment and recovery services (OAR chapter 410, division 130);~~

~~(ii) Chiropractic and osteopathic manipulation services (OAR chapter 410, division 130);~~

~~(iii) Hearing aids and related services (i.e., exams for the sole purpose of determining the need for or the type of hearing aid), (OAR chapter 410, division 129);~~

~~(iv) Home health services (OAR chapter 410, division 127), except when related to limited EPIV services (OAR chapter 410, division 148);~~

~~(v) Non-emergency medical transportation (OAR chapter 410, division 136);~~

~~(vi) Occupational therapy services (OAR chapter 410, division 131);~~

~~(vii) Physical therapy services (OAR chapter 410, division 131);~~

~~(viii) Private duty nursing services (OAR chapter 410, division 132), except when related to limited EPIV services;~~

~~(ix) Speech and language therapy services (OAR chapter 410, division 129);~~

~~(x) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140);~~

~~(xi) Other limitations as identified in individual Division program administrative rules, chapter 410.~~

~~(b) OHP with Limited Drug:~~

~~(A) Benefit Package identifier: BMM, BMD;~~

~~(B) Eligibility criteria: Eligible clients –are eligible for Medicare and Medicaid benefits;~~

~~(C) Coverage includes:~~

(i) Services covered by Medicare and OHP Plus as described in this rule ~~section (4)~~ of these rules;

(D) Limitations:

(i) The same as OHP Plus, as described in this rule ~~section (4)~~ of these rules;

(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to:

(I) Over-the-counter (OTC) drugs;

(II) Barbiturates (except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications).

(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug.

(F) Payment for services is limited to the ~~Medicaid~~ Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible;

(G) Cost sharing may apply to some covered services; however, cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package;

(d) Qualified Medicare Beneficiary (QMB)-Only:

(A) Benefit Package identifier code -MED:

(B) Eligibility criteria: Eligible clients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage.

(C) Coverage: It is limited to the co-insurance or deductible for the Medicare service. Payment is based on the ~~Medicaid~~ Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible, but no more than the Medicare allowable;

(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare.

(d) Citizen/Alien-Waived Emergency Medical (CAWEM):

(A) Benefit Package identifier CWM:

(B) Eligibility criteria: Eligible clients are -non-qualified aliens that are not eligible for other Medicaid programs pursuant to ~~Oregon Administrative Rules (OAR) 461-135-1070;~~

(C) Coverage is limited to:

(i) Emergency medical services as defined by 42 CFR 440.255. Sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part (the "prudent layperson standard" does not apply to the CAWEM emergency definition);

(ii) Labor and Delivery.

(D) Exclusions: The following services are not covered, even if they are sought as emergency services:

(i) Prenatal or postpartum care;

(ii) Sterilization;

(iii) Family Planning;

(iv) Preventive care;

(v) Organ transplants and transplant-related services;

(vi) Chemotherapy;

(vii) Hospice;

(viii) Home health;

(ix) Private duty nursing;

(x) Dialysis;

(xi) Dental services provided outside of an emergency department hospital setting;

(xii) Outpatient drugs or over-the-counter products;

(xiii) Non-emergency medical transportation;

(xiv) Therapy services;

(xv) Durable medical equipment and medical supplies;

(xvi) Rehabilitation services.

~~(ef) CAWEM Plus; CHIP Prenatal coverage for CAWEM (benefit code CWX) – refer to OAR 410-120-0030 for coverage.~~

(A) Benefit Package identifier code -CWX:

(B) Eligibility criteria: As defined in federal regulations and in the Children's Health Insurance Program (CHIP) state plan eligible clients are CAWEM pregnant women not eligible for Medicaid at or below 185 percent of the Federal Poverty Level (FPL).

(C) Coverage includes:

(i) Services covered by OHP Plus as described above^[kg1];

(D) Exclusions: The following services are not covered for CAWEM Plus^{this program}:

(i) Postpartum care, ~~(except when provided and billed as part of a global obstetric package code that includes the delivery procedure)~~;

(ii) Sterilization;

(iii) Abortion;

(iv) Death with dignity services;

(v) Hospice.

(E) The day after pregnancy ends, eligibility for medical services shall be based on eligibility categories established in OAR chapter 461^[kg2];

(45) Division clients are enrolled for covered health services to be delivered through one of the following means:

(a) Coordinated Care Organization (CCO):

(A) These clients are enrolled in a CCO that provides integrated and coordinated health care;

(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, -substance use disorder treatment and recovery, mental health services or dental care.

(b) Prepaid Health Plan (PHP):

(A) These clients are enrolled in a PHP for their medical, dental or mental health care;

(B) Most non-emergency services are obtained from the PHP or require a referral from the PHP that is responsible for the provision and reimbursement for the medical, dental or mental health service;

(c) Physician Care Organization (PCO):

(A) These clients are enrolled in a PCO for their medical care;

(B) Inpatient hospital services are not the responsibility of the PCO and are governed by the ~~Fee for Service~~ Division's Hospital Services Program rule (OAR chapter 410, Division 125).

~~(d) Primary Care Managers (PCM):~~

~~(A) These clients are enrolled with a PCM for their medical care;~~

~~(B) Most non-emergency services provided to clients enrolled with a PCM require referral from the PCM.~~

~~(de) Fee-for-service (FFS):~~

~~(A) These clients are not enrolled in a CCO, PHP, or PCO ~~or assigned to a PCM~~;~~

~~(B) Subject to limitations and restrictions in the Division's individual program rules, the client may ~~can~~ receive health care from any Division-enrolled provider that accepts FFS clients. The provider shall~~will~~ bill the Division directly for any covered service and shall~~will~~ receive a fee for the service provided.~~

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.329, 414.706, 414.707, 414.708, 414.710

410-120-1230 -

Client Co-payment

((1) Oregon Health Plan (OHP) Plus clients shall be responsible for paying a co-payment for some services. This co-payment shall be paid directly to the provider. A co-payment applies regardless of location of services rendered, i.e., provider's office or client's residence.

(2) The following services are exempt from co-payment:

(a) Emergency medical services, as defined in OAR 410-120-0000;

(b) Family planning services and supplies; and

(c) Prescription drug products for nicotine replacement therapy (NRT);

(d) Prescription drugs ordered through the Division's ~~of Medical Assistance Programs'~~ (Division's) Mail Order (a.k.a., Home-Delivery) Pharmacy program;

(e) Services to treat "health care-acquired conditions" (HCAC) and "other provider preventable conditions" (OPPC) services as defined in OAR 410-125-0450.

(3) The following clients are exempt from co-payments:

(a) Pregnant women;

(b) Children under age 19;

(c) Young adults in Substitute Care and in the Former Foster Care Youth Medical Program;

(de) Clients receiving services under the home and community based waiver and developmental disability waiver;

(ed) Inpatients in a hospital, nursing facility, or Intermediate Care Facility for the Mentally Retarded (ICF/MR); and

(fe) American Indian/Alaska Native (AI/AN) clients who are members of a federally recognized Indian tribe or receive services through Indian Health Services (IHS), tribal organization or services provided at an Urban Tribal Health Clinic as provided under Public Law 93-638;-

(g) Individuals receiving hospice care;

(h) Individuals eligible for the Breast and Cervical Cancer Program.

~~(4) Co-payment for services is due and payable at the time the service is provided unless exempted in sections (2) and (3) above. Services to a client may not ^{cannot} be denied solely because of an inability to pay an applicable co-payment. This does not relieve the client of the responsibility to pay the applicable co-payment, nor does it prevent the provider from attempting to collect any applicable co-payments from the client; the co-payment is a legal debt, and is due and payable to the provider of service.~~

~~(5) A client must pay the co-payment at the time service is provided unless exempted in (2) and (3) above.~~

~~(6) OHP Standard co-payments are eliminated for OHP Standard clients effective June 19, 2004. Elimination of co-payments by this rule shall supercede any other General Rules Program rule, 410-120-0000 et seq; any Oregon Health Plan rule, OAR 410-141-0000 et seq; or individual Division program rule(s), that contain or refer to OHP Standard co-payment requirements.~~

~~(57) Except for prescription drugs, one co-payment is assessed per provider, ^{per visit} per day unless otherwise specified in other Divisions' program administrative rules.~~

~~(68) Fee-^fFor-^sService co-payment requirements:~~

~~(a) The provider ~~must~~ ^{may} not deduct the co-payment amount from the usual and customary ~~billed amount~~ ^{fee} submitted on the claim. Except as provided in ~~subsection~~ (2) and (3) of this rule, the Division shall deduct the co-payment from the amount the Division pays to the provider (whether or not provider collects the co-payment from the client);~~

~~(b) If the Division's payment is less than the required co-payment, then the co-payment amount ~~is to~~ ^{is} equal to the Division's lesser required payment, unless the client or services ~~are~~ ^{is} exempt according to exclusions listed in ~~sections (2) and~~ (3) above. The client's co-payment shall constitute payment-in-full;~~

~~(c) Unless specified otherwise in individual program rules, and to the extent permitted under 42 CFR 1001.951 – 1001.952, the Division does not require providers to bill or collect a co-payment from the Medicaid client. The provider may choose not to bill or collect a co-payment from a Medicaid client; however, the Division ~~shall~~ ^{will} still deduct the co-payment amount from the Medicaid reimbursement made to the provider;~~

~~(d) Prescription drugs ordered through Division of Medical Assistance Program's (Division) Mail Order (a.k.a., Home-Delivery) Pharmacy program are exempt from co-payment.~~

~~(79) CCO, PHP, or PCO co-payment requirements:~~

~~(a) Unless specified otherwise in individual program rules, and to the extent permitted under 42 CFR 447.58 and 447.60, the Division does not require CCOs, PHP or PCOs to~~

bill or collect a co-payment from the Medicaid client. The CCO, PHP or PCO may choose not to bill or collect a co-payment from a Medicaid client; however, the Division ~~shall~~ will still deduct the co-payment amount from the Medicaid reimbursement made to the CCO, PHP or PCO;

(b) When a CCO, PHP or PCO is operating within the scope of the safe harbor regulation outlined in 42 CFR 1001.952(l), a CCO, PHP or PCO may elect to assess a co-payment on some of the services outlined in table 120-1230-1 but not all. The CCO, PHP or PCO must assure they are working within the provisions of 42 CFR 1003.102(b)(13).

~~(810)~~ Services that require co-payments are listed in Table 120-1230-1:

~~(911)~~ Table 120-1230-1

Stat. Auth.: ORS 413.042

Stat. Implemented: ORS 414.025 & 414.065 }

Table 120-1230-1

OHP Benefit Package Client Co-payment Requirements (Benefit Identifier)	OHP Plus (BMH,BMD, BMM)	OHP Standard (KIT)
Acupuncture services	\$3	\$0
Ambulance services (emergency)	\$0	\$0
Ambulatory Surgical Center	\$3	\$0
Audiology services	\$3	\$0
• Hearing Aids	\$0	NG
Chemical Dependency services		
• Outpatient services	\$3	\$0
• Medication dosing/dispensing, case management	\$0	\$0
• Inpatient hospital detoxification	\$0	\$0
Chiropractic services	\$3	NG
Dental services		
• Diagnostic –_(D0100-D0999)_oral examinations used to determine changes in the patient’s health or dental status, including x-rays, laboratory services and tests associated with making a diagnosis and/or treatment.	\$0	\$0
• Preventive services (D1000-D1999) routine cleanings fluoride, sealants	\$0	\$0
• Restorative treatment or other dental services (D2000-D9999)	\$3	\$0
DME and supplies	\$0	\$0
Home visits for		
• Home health	\$3	NG
• Private duty nursing	\$3	NG
• Enteral/Parenteral	\$3	\$0
Hospital		
• Inpatient care	\$0	\$0
• Outpatient surgery	\$3	\$0
• Emergency room services	\$0	\$0
• Outpatient, other	\$3	\$0
• Non-emergent visit performed in the ER	\$3	\$0
Laboratory test	\$0	\$0
Mental Health services		
• Inpatient hospitalization_- includes ancillary, facility and professional fees (DRG 424-432);	\$3	\$0
• Initial assessment/evaluation by psychiatrist or psychiatric mental health nurse practitioners (90801);	\$3	\$0
• Outpatient hospital- Electroconvulsive (ECT) treatment (Revenue code 901) including facility, professional fees (90870-90871) and anesthesiology fees (00104);	\$3	\$0
• Medication Management by psychiatrist or psychiatric	\$0	\$0

OHP Benefit Package Client Co-payment Requirements (Benefit Identifier)	OHP Plus (BMH,BMD, BMM)	OHP Standard (KIT)
mental health nurse practitioner (90862); <ul style="list-style-type: none"> • Consultation between psychiatrist/psychiatric mental health nurse practitioner and primary care physician (90887) 	\$0	\$0
Naturopathic services	\$3	\$0
Podiatry services	\$3	\$0
Prescription drugs <ul style="list-style-type: none"> • Non-preferred PDL or generics in non-PDL classes costing >\$10 • Preferred PDL generic or generics in non-PDL classes costing <\$10 • Preferred PDL brand • All other brands Refer to OAR 410-121-0030 for PDL list PDL list is not applicable to those enrolled in MCO, contact the MCO for details.	\$1 \$0 \$0 \$3	\$0 \$0 \$0 \$0
Professional visits for <ul style="list-style-type: none"> • Primary care, including urgent care by a Physician, Physician Assistant, Certified Nurse Practitioner • Specialty care • Office medical procedures • Surgical procedures • PT/OT/Speech 	\$3 \$3 \$0 \$0 \$3	\$0 \$0 \$0 \$0 NG
Radiology <ul style="list-style-type: none"> • Diagnostic procedures • Treatments 	\$0 \$0	\$0 \$0
Vision services <ul style="list-style-type: none"> • Exams- for medical purposes or solely for glasses • Frames, contracts, corrective devices 	\$3 \$0	NG NG

410-123-1060

Definition of Terms

(1) Anesthesia — The following depicts the Division of Medical Assistance Programs' (Division) usage of certain anesthesia terms; however, for further details refer also to the Oregon Board of Dentistry administrative rules (OAR chapter 818, division 026):

(a) Conscious Sedation:

(A) Deep Sedation — A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance maintaining a patient airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained;

(B) Minimal sedation — A minimally depressed level of consciousness, produced by non-intravenous pharmacological methods, that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous pharmacological method is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single non-intravenous pharmacological method in minimal sedation;

(C) Moderate sedation — A drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained;

(b) General Anesthesia — A drug-induced loss of consciousness during which the patient is not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patient airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired;

(c) Local anesthesia — The elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug;

(d) Nitrous Oxide Sedation — An induced controlled state of minimal sedation, produced solely by the inhalation of a combination of nitrous oxide and oxygen, in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command;

(2) Citizen/Alien-Waived Emergency Medical (CAWEM) — Refer to OAR 410-120-0000 for definition of clients who are eligible for limited emergency services under the CAWEM benefit package. The definition of emergency services does not apply to CAWEM clients. OAR 410-120-1210 provides a complete description of limited emergency coverage pertaining to the CAWEM benefit package.

(3) Covered Services — Services on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List) that have been funded by the Legislature and identified in specific program rules. Services are limited as directed by General Rules — Excluded Services and Limitations (OAR 410-120-1200), the Division's Dental Services Program rules (chapter 410, division 123) and the Prioritized List. Services that are not considered emergency dental services as defined by OAR 410-123-1060(12) are considered routine services.

(4) Dental Hygienist — A person licensed to practice dental hygiene pursuant to State law.

(5) Dental Hygienist with Expanded Practice Dental Hygiene Permit (EPDH) — A person licensed to practice dental hygiene with an EPDH permit issued by the Board of Dentistry and within the scope of an EPDH permit pursuant to State law.

(6) Dental Practitioner — A person licensed pursuant to State law to engage in the provision of dental services within the scope of the practitioner's license and/or certification.

(7) Dental Services — Services provided within the scope of practice as defined under State law by or under the supervision of a dentist or dental hygienist, or denture services provided within the scope of practice as defined under State law by a denturist.

(8) Dental Services Documentation — Must meet the requirements of the Oregon Dental Practice Act statutes; administrative rules for client records and requirements of OAR 410-120-1360, "Requirements for Financial, Clinical and Other Records;" and any other documentation requirements as outlined in the Dental rules.

(9) Dentally Appropriate — In accordance with OAR 410-141-0000, services that are required for prevention, diagnosis or treatment of a dental condition and that are:

(a) Consistent with the symptoms of a dental condition or treatment of a dental condition;

(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community, evidence-based medicine and professional standards of care as effective;

(c) Not solely for the convenience of a OHP member or a provider of the service; and

(d) The most cost effective of the alternative levels of dental services that can be safely provided to a Division member.

(10) Dentist — A person licensed to practice dentistry pursuant to State law.

(11) Denturist — A person licensed to practice denture technology pursuant to State law.

(12) Direct Pulp Cap — The procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair.

(13) Emergency Services:

(a) Refer to OAR 410-120-0000 for the complete definition of emergency services. (This definition of emergency services does not apply to CAWEM clients. OAR 410-120-1210 provides a complete description of limited emergency coverage pertaining to the CAWEM benefit package);

(b) Covered services for an emergency dental condition manifesting itself by acute symptoms of sufficient severity requiring immediate treatment. This includes services to treat the following conditions:

(A) Acute infection;

(B) Acute abscesses;

(C) Severe tooth pain;

(D) Unusual swelling of the face or gums; or

(E) A tooth that has been avulsed (knocked out);

(c) The treatment of an emergency dental condition is limited only to covered services. The Division recognizes that some non-covered services may meet the criteria of treatment for the emergency condition; however, this rule does not extend to those non-covered services. Routine dental treatment or treatment of incipient decay does not constitute emergency care;

~~(d) The OHP Standard Benefit Package includes a limited emergency dental benefit. Refer to OAR 410-123-1670.~~

(14) Hospital Dentistry — Dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR 410-123-1490) are provided in an ambulatory surgical center, inpatient, or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).

(15) Medical Practitioner — A person licensed pursuant to State law to engage in the provision of medical services within the scope of the practitioner's license and/or certification.

(16) Procedure Codes — The procedure codes in the Dental Services rulebook (OAR chapter 410, division 123) refer to Current Dental Terminology (CDT), unless otherwise noted. Codes listed in this rulebook and other documents incorporated in rule by reference are subject to change by the American Dental Association (ADA) without notification.

(17) Standard of Care — What reasonable and prudent practitioners would do in the same or similar circumstances.

Stat. Auth.: ORS 413.042, 414.065 & 414.707

Stats. Implemented: ORS 414.065 & 414.707

410-123-1200

Services Not To Be Billed Separately

(1) Services that are not to be billed separately may be included in the Current Dental Terminology (CDT) codebook and may not be listed as combined with another procedure, however they are considered to be either minimal, included in the examination, part of another service, or included in routine post-op or follow-up care.

(2) The following services do not warrant an additional fee:

(a) Alveolectomy/Alveoloplasty in conjunction with extractions;

(b) Cardiac and other monitoring;

(c) Curettage and root planing — per tooth;

(d) Diagnostic casts;

(e) Dietary counseling;

(f) Direct pulp cap; ~~(exception: direct pulp cap is covered separately for OHP Standard clients; the Standard benefit plan does not cover restorations);~~

(g) Discing;

(h) Dressing change;

(i) Electrosurgery;

(j) Equilibration;

(k) Gingival curettage — per tooth;

(l) Gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth;

(m) Indirect pulp cap;

(n) Local anesthesia;

(o) Medicated pulp chambers;

(p) Occlusal adjustments;

(q) Occlusal analysis;

- (r) Odontoplasty;
- (s) Oral hygiene instruction;
- (t) Periodontal charting, probing;
- (u) Post removal;
- (v) Polishing fillings;
- (w) Post extraction treatment for alveolaritis (dry socket treatment) if done by the provider of the extraction;
- (x) Pulp vitality tests;
- (y) Smooth broken tooth;
- (z) Special infection control procedures;
- (aa) Surgical procedure for isolation of tooth with rubber dam;
- (bb) Surgical splint;
- (cc) Surgical stent; and
- (dd) Suture removal.

Stat. Auth.: ORS 413.042, 414.065 & 414.707
Stats. Implemented: ORS 414.065 & 414.707

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 includes, but are not limited to:

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

(ii) Dental diagnosis and treatment which 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 must provide EPSDT services for eligible 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 Prioritized List of Health Services (Prioritized List); and

(ii) The "Oregon Health Plan (OHP) — Recommended Dental Periodicity Schedule," dated January 1, 2010, incorporated by reference and posted on the Division Web site in the Dental Services Provider Guide document at www.oha.state.or.us/policy/healthplan/guides/dental/main.html^[kg1];

(b) Restorative, periodontal and prosthetic treatments:

(A) Treatments must be consistent with the prevailing standard of care, documentation must be included in the client's charts to support the treatment, 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) DIAGNOSTIC SERVICES:

(a) Exams:

(A) For children (under 19 years of age):

(i) The Division shall reimburse exams (billed as 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 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 should not bill D0140 and D0170 for routine dental visits;

(D) The Division only covers oral exams 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 furnished by a dental hygienist (with or without an expanded practice permit);

(b) Assessments 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. An oral assessment is included in the exam;

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

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

(B) When performed by a medical practitioner, the Division shall cover:

(i) Only for children under 7 years of age; and

(ii) A maximum of once a year;

(C) Medical practitioners performing D0191 shall bill the client's medical coverage for reimbursement (Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) if the member is enrolled member, or the Division for if fee-for-service clients);

(D) The maximum limits for this procedure for dental practitioners do not affect the maximum limits for medical providers, and vice versa; and

(E) 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 must 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 10 periapicals and two bitewings for a total of 12 films;

(ii) For clients ages 12 and older - a minimum of 10 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 was unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records must be included in the client's records;

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

(3) 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/or 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) For children under 7 years of age, topical fluoride varnish may be applied by a medical practitioner during a medical visit:

(i) Bill the Division directly regardless of whether the client is ~~fee-for-service (FFS)~~ or enrolled in a CCO or a PHP;

(ii) Bill using a professional claim format with the appropriate CDT code (D1206 — Topical Fluoride Varnish);

(D) Additional topical fluoride treatments may be available, up to a total of four 4 treatments per client within a 12-month period, when high-risk conditions or oral health factors are clearly documented in chart notes for the following 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 year 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;

(E) 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 10 services within a three-month period;

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

(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.

(4) RESTORATIVE SERVICES:

(a) Restorations — amalgam and composite:

(A) The Division shall cover resin-based composite restorations only for anterior teeth (D2330-D2390) and one surface posterior teeth (D2391);

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

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

(D) 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 must 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) The Division reimburses for a surface once in each treatment episode regardless of the number or combination of restorations;

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

(b) 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% of the tooth structure must be remaining for coverage of the core buildup. ~~The Division may not cover core buildup if the crown is not covered under the client's OHP benefit package.~~^[kg2]

(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) must 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) ~~of Medical Assistance Programs~~);

(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 millimeter and over, documentation must 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 tooth to be crowned is clasp/abutment tooth in partial denture, both prognosis for crown itself and tooth's contribution to partial denture must 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.

(5) ENDODONTIC SERVICES:

~~(a) Pulp capping:~~

~~(A) The Division includes direct and indirect pulp caps in the restoration fee; no additional payment shall be made for clients with the OHP Plus benefit package;~~

~~(B) The Division covers direct pulp caps as a separate service for clients with the OHP Standard benefit package because restorations are not a covered benefit under this benefit package;~~

~~(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):

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

(lll) 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;

(be) Endodontic retreatment and apicoectomy/periradicular surgery:

(A) The Division does not cover retreatment of a previous root canal or apicoectomy/periradicular surgery 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;

(cd) 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;

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

(ef) Apexification/recalcification and pulpal regeneration procedures:

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

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

(6) 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 increase periodontal maintenance (chart notes, pocket depths and radiographs);

(d) Records must 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).

(7) 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 must 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 must 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 must 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 must 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 10 years only if dentally appropriate;

(C) The ten year limitations apply to the client regardless of the client's OHP_[kg3] or Dental Care Organization (DCO),/Coordinated Care Organization (CCO) enrollment status at the time client's last denture or partial was received. For example: a client receives a partial on February 1, 2002, and becomes a FFS OHP_[kg4] 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, 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/or 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 4 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 2 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 (D5670D5671):
 - (A) Is covered for clients age 16 and older a maximum of once every 10 years, per arch;
 - (B) Ten years or more must 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 ~~10~~ 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 must be documentation of a current reline which 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.

(8) 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 must 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.

(9) 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, 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 (including 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 ICD9 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, 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 must 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/or 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.

(10) ORTHODONTIA SERVICES:

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

(A) With the ICD-9-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 must be included in the client's record and a copy sent with the PA request;

(c) Documentation in the client's record must 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 must 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.

(11) 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 must 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

Rule rewritten

410-123-1540

Citizen/Alien-Waived Emergency Medical (CAWEM)

(1) CAWEM clients who are not pregnant (benefit package identifier CWM) have a limited benefit package. Dental coverage is limited to dental services provided in an emergency department hospital setting. (Refer to OAR 410-120-1210(4)(e)).

(2) CAWEM clients who are pregnant (benefit package identifier CWX) receive the OHP Plus dental benefit package as described in OAR 410-123-1260.

(3) All CAWEM clients are exempt from enrollment in a Dental Care Organization (DCO) or Coordinated Care Organization (CCO). Providers must bill the Division directly for any allowable services provided.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-125-0020

Retroactive Eligibility

(1) The Division of Medical Assistance Programs (Division) may pay for services provided to an individual ~~person~~ who does not have Medicaid coverage at the time services are provided if the individual ~~person~~ is made retroactively eligible for medical assistance and eligibility is extended back to the date services were provided. Contact the local branch concerning possible retroactive eligibility. In some cases, the date ~~you~~^[kg1] ~~of branch~~ ~~contact the branch~~ may be considered the date of application for eligibility.

(2) ~~Retroactive authorization~~^[kg2]: ~~When clients are not eligible at the time services are provided, it is not possible to get prior authorization (PA) for service. However~~ ~~a~~ Authorization for payment may be given after the service is provided under limited circumstances. For additional prior authorization PA information see Hospital Services Program Oregon administrative rule (OAR) 410-125-00800124 (Hospital Services Program) and 410-125-0047.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0080

Inpatient Services

(1) Elective (not urgent or emergent) hospital admission:

(a) Coordinated Care Organization (CCO), Fully-Capitated Health Plan (FCHP), and Mental Health Organization (MHO) clients; —~~e~~Contact the client's CCO, FCHP, or MHO or FCHP. The health plan may have different prior authorization (PA) requirements than the Division of Medical Assistance Programs (Division);

(b) Medicare clients;— The Division does not require PA for inpatient services provided to clients with Medicare Part A or B coverage;

(c) ~~For Division clients: Oregon Health Plan (OHP) clients covered by the Oregon Health Plan (OHP) Plus Benefit Package; and OHP Standard Benefit Packages referenced in 410-125-0047(2)(d)~~

(A) For a list of medical and surgical procedures that require PA, see the Division's Medical-Surgical Services Program, Oregon administrative rules (OARs or rules); chapter 410, division 130, specifically OAR 410-130-0200, table 130-0200-1, unless they are urgent or emergent defined in OAR 410-125-0401.

(B) For PA, contact the Division unless otherwise indicated in the Medical-Surgical Service Program rules, specifically OAR 410-130-0200, Table 130-0200-1.

(2) Transplant services:

(a) Complete rules for transplant services are in the Division's Transplant Services Program administrative rules (OAR chapter 410, division 124);

(b) Clients are eligible for transplants covered by the Oregon Health Services Health Evidence Review Commission's Prioritized List of Health Services (Prioritized List). See the Transplant Services Program administrative rules for criteria. For clients enrolled in a FCHP, contact the plan for authorization. Clients not enrolled in a FCHP, contact the Division's Medical Director's office.

(3) Out-of-~~s~~State non-contiguous hospitals:

(a) All non-emergent and /non-urgent services provided by hospitals more than 75 miles from the Oregon border require PA;

(b) Contact the Division's Medical Director's office for authorization for clients not enrolled in a Prepaid Health Plan (PHP). For clients enrolled in a PHP, contact the plan.

(4) Out-of-sState contiguous hospitals: ~~services~~ The Division prior authorizes services provided by contiguous-area hospitals, less than 75 miles from the Oregon border, ~~are~~ prior authorized following the same rules and procedures governing as in-sState providers.

(5) Transfers to another hospital:

(a) Transfers for the purpose of providing a service listed in the Medical-Surgical Service Program rules, specifically OAR 410-130-0200, Table 130-0200-1, e.g., inpatient physical rehabilitation care, requires PA — Contact the Division-contracted Quality Improvement Organization (QIO);

(b) ~~For t~~Transfers to a ~~long-long-term, acute-acute-care~~ hospital, skilled nursing facility, intermediate care facility or swing bed, — contact Aging and People with Disabilities (APD). APD reimburses nursing facilities and swing beds through contracts with the facilities. For CCO and FCHP clients, — transfers require authorization and payment (for first 20 days) from the CCO or FCHP;

(c) ~~For t~~Transfers for the same or lesser level inpatient care to a general acute-care hospital, — the Division shall cover transfers, including back transfers, ~~which that~~ are primarily for the purpose of locating the patient closer to home and family, when the transfer is expected to result in significant social or/psychological benefit to the patient:

(A) The assessment of significant benefit shall be based on the amount of continued care the patient is expected to need (at least seven days) and the extent to which the transfer locates the patient closer to familial support;

(B) Payment for tTransfers not meeting these guidelines may be denied on the basis of post-payment review;

(d) Exceptions:

(A) Emergency transfers do not require PA;

(B) In-sState or contiguous non-emergency transfers for the purpose of providing care that is unavailable in the transferring hospital do not require PA unless the planned service is listed in the Medical-Surgical Service Program rules, specifically OAR 410-130-0200, Table 130-0200-1;

(C) All non-urgent transfers to out-of-sState, non-contiguous hospitals require PA.

(6) Dental procedures provided in a hospital setting:

(a) For prior authorization requirements, see the Division's Dental Services Program rules, specifically OAR 410-123-1260 and 410-123-1490;

(b) Emergency dental services do not require PA;

(c) For prior authorization for fee-for-service clients, contact the Division's Dental Services Program analyst. (See the Division's Dental Services Program Supplemental Guide information, online^(kg1));

(d) For clients enrolled in a CCO or FCHP, contact the client's health plan^{FCHP}.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0085

Outpatient Services

(1) Outpatient services that may require prior authorization (PA) include (see the individual program in the Division's of Medical Assistance Programs (Division^(kg1)), Oregon administrative rules (OARs or rules):

- (a) Physical Therapy (chapter 410, division 131);
- (b) Occupational Therapy (chapter 410, division 131);
- (c) Speech Therapy (chapter 410, division 129);
- (d) Audiology (chapter 410, division 129);
- (e) Hearing Aids (chapter 410, division 129);
- (f) Dental Procedures (chapter 410, division 123);
- (g) Drugs (chapter 410, division 121);
- (h) Apnea monitors, services, and supplies (chapter 410, division 131);
- (i) Home Parenteral/Enteral Therapy (chapter 410, division 148);
- (j) Durable Medical Equipment and Medical supplies (chapter 410, division 122);
- (k) Certain hospital services.

(2) The National Drug Code (NDC) must be included on the electronic (837I) and paper (UB 04) claims for physician administered drug codes required by the Deficit Reduction Act of 2005.

(3) Outpatient surgical procedures:

(a) Coordinated Care Organization (CCO) and Fully-Capitated Health Plan (FCHP) clients: Contact the client's FCHP health plan. The health plan may have different PA requirements than the Division of Medical Assistance Programs (Division). Some services are not covered under FCHP contracts and require PA from the Division, or the Division's Dental Program analyst;

(b) Medicare clients enrolled in a CCO or an FCHP: These services must be authorized by the plan even if Medicare is the primary payer. Without this authorization, the provider shall not be paid beyond any Medicare payments (see also OAR 410-125-0103);

(c) For Division clients on the OHP Plus benefit package and Standard benefit package as referenced in 410-125-0047(2)(d) ~~Division clients:~~

(A) Surgical procedures listed in OAR 410-125-0080 require PA when performed in an outpatient or day surgery setting, unless they are urgent or emergent.;

(B) Contact the Division for PA (unless indicated otherwise in OAR 410-125-0080).;

(d) Out-of-State services — Outpatient services provided by hospitals located less than 75 miles from the border of Oregon do not require prior authorization unless specified in the Division's Hospital Services Program rules. All non-urgent or non-emergent services provided by hospitals located more than 75 miles from the border of Oregon require ~~prior authorization~~ PA. For clients enrolled in a CCO or an FCHP, contact the health plan for authorization. For clients not enrolled in a ~~prepaid~~ health plan, contact the Division's Medical Unit.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-130-0240

Medical Services

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

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

~~(a) Oregon Health Plan Standard benefit package covers acupuncture services only for chemical dependency;~~

~~(b) Oregon Health Plan Plus benefit package covers Coverage for acupuncture services by an enrolled acupuncture provider are subject to according to the HERC List of Prioritized Services and the member's benefit plan.~~

(3) Coverage for chiropractic services provided by an enrolled chiropractor isare subject to the HERC ~~List of~~ Prioritized List ~~Services,~~ and benefit plan for:

(a) Diagnostic visits, including evaluation and management services;

(b) Chiropractic manipulative treatment;

(c) Laboratory and radiology services.

(4) Maternity care and delivery:

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

(b) Within the home setting the Division may consider payment for appropriate supplies in addition to delivery payment. The additional payment for supplies includes all supplies, equipment, staff assistance, ~~new born~~ newborn screening cards, and local or ~~topical~~ anesthetics;

(c) The Division may consider payment for physician-administered medications associated with delivery except for local or topical anesthetics;

(d) When labor management conducted by a licensed direct entry midwife (LDEM) does not result in a delivery and the client is appropriately transferred the provider shall code for labor management only. Bill code 59899 and attach a report;

(e) For multiple births, use the appropriate CPT code for the first vaginal or cesarean delivery that includes antepartum and postpartum care, and the subsequent births under the respective delivery only code. {For example, for total obstetrical care with cesarean delivery of twins, bill code 59510 for the first delivery and code 59514 for the second delivery.}

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

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

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

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

(7) Oral ~~h~~Health ~~s~~Services provided by medical practitioners may include an oral assessment and application of topical fluoride varnish during a medical visit to children under the age of ~~seven~~7 years. Refer to ~~the Division's OAR 410-123-1260 (Dental Services Program)~~ rule 410-123-1260.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

410-131-0120 Limitations of Coverage and Payment

~~(1) Physical and occupational therapy (PT/OT) services are not covered under the Standard Benefit Package. See General Rules, 410-120-1210 for additional information.~~

(12) Oregon Health Plan (OHP) Plus clients shall be responsible for paying a co-payment for some services. This co-payment shall be paid directly to the provider. See OAR 410-120-1230, *Client Co-payment*^[kg1], and Table 120-1230-1 for specific details.

(23) The provision of PT/OT evaluations and therapy services require a prescribing practitioner referral, and services must be supported by a therapy plan of care signed and dated by the prescribing practitioner (see OAR 410-131-0080).

(34) PT/OT initial evaluations and re-evaluations do not require Prior Authorization (PA), but are limited to:

(a) Up to two initial evaluations in any 12-month period; and

(b) Up to four re-evaluation services in any 12-month period;

(45) Reimbursement is limited to the initial evaluation when both the initial evaluation and a re-evaluation are provided on the same day.

(56) All other occupational and physical therapy treatments require PA. See also OAR 410-131-0160 and Table 131-0160-1.

(67) ~~Program Information~~^[kg2]— A licensed occupational or physical therapist, or a licensed occupational or physical therapy assistant under the supervision of a therapist, must be in constant attendance while therapy treatments are performed:

(a) Duration - Therapy treatments ~~may~~ must not exceed one hour per day each for occupational and physical therapy;

(b) Modalities;

(A) Require PA;

(B) Up to two modalities may be authorized per day of treatment;

(C) Need to be billed in conjunction with a therapeutic procedure code; and

(D) Each individual supervised modality code may be reported only once for each client encounter. See Table 131-0160-1.

(c) Massage therapy is limited to two ~~(2)~~ units per day of treatment, and ~~shall~~ will only be authorized in conjunction with another therapeutic procedure or modality;

(78) Supplies and materials for the fabrication of splints must be billed at the acquisition cost, and reimbursement ~~may~~ will not exceed the Division's maximum allowable in accordance with the physician fee schedule. Acquisition cost is purchase price plus shipping. Off-the-shelf splints, even when modified, are not included in this service;

(89) ~~Services Not Covered~~—The following services are not covered:

(a) Services not medically appropriate;

(b) Services that are not paired with a funded diagnosis on the Health Services Commission's Prioritized List of Health Services pursuant to ~~adopted under~~ OAR 410-141-0520;

(c) Work hardening;

(d) Back school/back education classes;

(e) Hippotherapy (e.g. horse or equine-assisted therapy);

(f) Services included in OAR 410-120-1200 Excluded Services Limitations;

(g) Durable medical equipment and medical supplies other than those splint supplies listed in Table 131-0120-1, OAR 410-131-0280; and

(h) Maintenance therapy (see OAR 410-131-0100).

(910) Physical capacity examinations are not a part of the PT/OT program, but may be reimbursed as aAdministrative eExaminations when ordered by the local branch office. See the Division's OARs 410, dDivision 150 for information on aAdministrative examinations and report billing.

(1014) Table 131-0120-1

Stat. Auth.: ORS 413-042

Stats. Implemented: ORS 688.135, 414.065

Table 131-0120-1 Services That Do Not Require Payment Authorization

This table is arranged to improve clarity and is not intended to provide complete guidance on service coverage. Refer to OARs 410-141-0480, 410-141-0500, and 410-141-0520 for information on covered services.

Application of splints

29105
29125
29126
29130
29131

Supplies to create splints

Q4017
Q4018
Q4019
Q4020
Q4021
Q4022
Q4023
Q4024
Q4049
Q4051

410-138-0000

Targeted Case Management Definitions

The following definitions apply to ~~Oregon administrative rules (OAR or rule)~~OAR 410-138-0000 through 410-138-0420:

- (1) Assessment means ~~the~~ — ~~T~~the act of gathering information and reviewing historical and existing records of an eligible client in a target group to determine the need for medical, educational, social, or other services. To perform a complete assessment, the case manager shall gather information from family members, medical providers, social workers, and educators, if necessary.
- (2) Care Plan means ~~a~~A Targeted Case Management (TCM) Care Plan that is a multidisciplinary plan that contains a set of goals and actions required to address the medical, social, educational, and other service needs of the eligible client based on the information collected through an assessment or periodic reassessment.
- (3) Case Management means ~~S~~services furnished by a case manager to assist individuals eligible under the Medicaid State plan in gaining access to and effectively using needed medical, social, educational, and other services (such as housing or transportation) in accordance with 42 CFR 441.18. See also definition for Targeted Case Management.
- (4) Centers for Medicare and Medicaid Services (CMS) means ~~T~~the Ffederal agency under the U.S. Department of Health and Human Services that provides the Ffederal funding for Medicaid and Children’s Health Insurance Program (CHIP). ~~The agency was formerly called the Health Care Financing Administration (HCFA).~~
- (5) Department means the ~~—~~ Department of Human Services (Department).
- (6) Division means the ~~–~~ Division of Medical Assistance Programs ~~(Division).~~
- (7) Duplicate ~~payments~~ payments mean ~~—~~ ~~p~~Payments are considered “duplicate” if more than one payment is made for the same services to meet the same need for the same client at the same point in time.
- (8) Early intervention (EI) means ~~s~~Services for preschool children with disabilities from birth until three years of age, including Indian children and children who are homeless and their families.
- (9) Early childhood special education (ECSE) means ~~F~~free, specially designed instruction to meet the unique needs of a preschool child with a disability, three years of age until the age of eligibility for public school, including instruction in

physical education, speech-language services, travel training, and orientation and mobility services. Instruction is provided in any of the following settings: home, hospitals, institutions, special schools, classrooms, and community childcare or preschool settings.

(10) Early Intervention/Early Childhood Special Education (EI/ECSE) services means—~~s~~Services provided to a preschool child with disabilities, eligible under the Individuals with Disabilities Education Act (IDEA), from birth until they are eligible to attend public school, pursuant to the eligible child's Individualized Family Service Plan (IFSP).

(11) EI/ECSE Case manager (i.e., service coordinator) means—~~a~~An employee of the EI/ECSE contracting or subcontracting agency meeting the personnel standards requirements in OAR 581-015-2900. The EI/ECSE case manager serves as a single point-of-contact and is responsible for coordinating all services across agency lines for the purpose of assisting an eligible client to obtain needed medical, social, educational, developmental and other appropriate services (such as housing or transportation) identified in the eligible client's care plan in coordination with the client's IFSP.

(12) EI/ECSE TCM ~~Targeted Case Management P~~rogram means—~~as a service under the State plan, and includes case management services furnished to eligible EI/ECSE preschool children age 0-5 with disabilities, assisting them to gain access to needed medical, social, educational, developmental and other appropriate services (such as housing or transportation) in coordination with their IFSP. EI/ECSE TCM providers must meet the criteria for the provision of special education programs approved by the State Superintendent of Public Instruction qualifying such programs for s~~State reimbursement under OAR 581-015-2710 EI/ECSE; and must be contractors with the Oregon Department of Education in the provision of EI/ECSE services or be sub-contractors with such a contractor. Medicaid reimbursement for EI/ECSE TCM services is available only to eligible clients in the target group and does not restrict an eligible client's free choice of providers.

(13) Eligible client means—~~a~~An individual who is found deemed eligible for Medicaid or the Children's Health Insurance Program (CHIP) by the Oregon Health Authority (Authority) and eligible for case management services (including TCM services) as defined in the Medicaid State plan, at the time the services are furnished. ~~TCM services are allowable only for clients who are categorically eligible. The Medicaid State Plan does not allow TCM services for clients who are covered under the Medicaid standard benefit package.~~

(14) Federal Financial Participation (FFP) means—~~T~~the portion paid by the federal government to states for their share of expenditures for providing Medicaid services. FFP was created as part of the Title XIX, Social Security Act of 1965. There are two objectives that permit claims under FFP. They are:

(a) To assist individuals eligible for Medicaid to enroll in the Medicaid program;
and

(b) To assist individuals on Medicaid to access Medicaid providers and services.
The second objective involves TCM.

(15) Federal Medical Assistance Percentage (FMAP) means —~~t~~The percentage of federal matching dollars available to a state to provide Medicaid services. The FMAP is calculated annually based on a three-year average of state per capita personal income compared to the national average. The formula is designed to provide a higher federal matching rate to states with lower per capital income. No state receives less than 50% or more than 83%.

(16) Individualized Family Service Plan (IFSP) means —~~a~~A written plan of early childhood special education, related services, early intervention services, and other services developed in accordance with criteria established by the State Board of Education for each child eligible for services. (See OAR 581-015-2700 to 581-015-2910, Early Intervention and Early Childhood Special Education Programs).

(17) Medical Assistance Program means —~~a~~A program administered by the Division that provides and pays for health services for eligible Oregonians. The Oregon Medical Assistance Program includes TCM services provided to clients eligible under the Oregon Health Plan (OHP) Title XIX^[kg2], and the Children's Health Insurance Program (CHIP) Title XXI.

(18) Monitoring means —~~o~~Ongoing face-to-face or other contact to conduct follow-up activities with the participating eligible client or the client's health care decision makers, family members, providers or other entities or individuals when the purpose of the contact is directly related to managing the eligible client's care to ensure the care plan is effectively implemented.

(19) Oregon Health Plan (OHP) means —~~t~~The Medicaid program in Oregon ~~that is known as the OHP, and that is governed by~~which consists of a series of laws passed by the Oregon Legislature with the intention of providing universal access to healthcare to Oregonians. OHP is also governed by many federal laws^[kg3].

(20) Reassessment means —~~p~~Periodically re-evaluating the eligible client to determine whether or not medical, social, educational, or other services continue to be adequate to meet the goals and objectives identified in the care plan. Reassessment decisions include those to continue, change, or terminate TCM services. A reassessment must be conducted at least annually or more frequently if changes occur in an eligible client's condition; or when resources are inadequate or the service delivery system is non-responsive to meet the client's identified service needs.

(21) Referrals means —pPerforming activities such as scheduling appointments that link the eligible client with medical, social, or educational providers, or other programs and services, and follow-up and documentation of services obtained.

(22) Targeted Case Management (TCM) Services means —cCase management services furnished to a specific target group of eligible clients under the Medicaid State plan to gain access to needed medical, social, educational, and other services (such as housing or transportation).

(23) Unit of Government means —aA city, a county, a special purpose district, or other governmental unit in the sState.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-138-0007

Targeted Case Management — Covered Services

(1) Targeted case management (TCM) services shall be furnished only to assist individuals eligible under the Medicaid State plan in gaining access to and effectively using needed medical, social, educational, and other services (such as housing or transportation) in accordance with 42 CFR 441.18~~category~~eligible clients. The Medicaid State Plan does not allow TCM services for clients who are covered under the Medicaid Standard benefit package.

(2) ~~TCM~~Targeted case management services billed to Medicaid must be for allowable activities and include one or more of the following components:

(a) Assessment of an eligible client in the target group to determine the need for medical, educational, social, or other services as follows:

(A) Taking client history;

(B) Identifying the needs of the client, and completing related documentation;

(C) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible client;

(D) Periodically reassessing a client to determine ~~whether~~if the client's needs or preferences have changed. A reassessment must be conducted at least annually or more frequently if changes occur in an individual's condition;

(b) Development of a care plan based on the information collected through the assessment or periodic reassessment, specifying the goals and actions to address the medical, social, educational, and other services needed by the eligible client. This may include:

(A) Active participation of the eligible client in the target group; or

(B) Working with the eligible client or the eligible client's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the eligible client;

(c) Referral, linking and coordination of services and related activities including but not limited to:

(A) Scheduling appointments for the eligible client in the target group to obtain needed services; and

(B) Activities that help link the eligible client with medical, social, or educational providers, or other programs and services (e.g., food vouchers, transportation, child care, or housing assistance) that address identified needs and achieve goals specified in the care plan. The case management referral activity is completed once the referral and linkage have been made;

(C) Reminding and motivating the client to adhere to the treatment and services schedules established by providers;

(d) Monitoring or ongoing face-to-face or other contact;

(A) Monitoring and follow-up activities include activities and contacts:

(i) To ensure the care plan is effectively implemented;

(ii) To help determine ~~whether~~ if the services are being furnished in accordance with the eligible client's care plan;

(iii) To determine ~~whether~~ the care plan adequately addresses the needs of the eligible client in the target group;

(iv) To adjust the care plan to meet changes in the needs or status of the eligible client;

(B) Monitoring activities may include contacts with:

(i) The participating eligible client in the target group;

(ii) The eligible client's healthcare decision makers, family members, providers, or other entities or individuals when the purpose of the contact is directly related to the management of the eligible client's care.

(3) TCM services billed to Medicaid must be documented in individual case records for all individuals receiving case management. The documentation must include:

(a) The name of the individual;

(b) The dates of the case management services;

(c) The name of the provider agency (if relevant) and the person providing the case management service;

(d) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;

- (e) Whether the individual has declined services in the care plan;
- (f) The need for, and occurrences of, coordination with other case managers;
- (g) A timeline for obtaining needed services;
- (h) A timeline for reevaluation of the plan.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

~~Hist.: DMAP 32 2008(Temp), f. & cert. ef. 10-2-08 thru 3-27-09; DMAP 43 2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 22 2010, f. 6-30-10, cert. ef. 7-1-10; DMAP 41 2010, f. 12-28-10, cert. ef. 1-1-11~~

410-138-0009

Targeted Case Management — Services Not Covered

- (1) Targeted Case Management (TCM) services do not cover:
- (a) Direct delivery of an underlying medical, educational, social, or other service, to which the eligible client has been referred;
 - (b) Providing transportation to a service to which an eligible client is referred;
 - (c) Escorting an eligible client to a service;
 - (d) Providing child care so that an eligible client may access a service;
 - (e) Contacts with individuals who are not categorically eligible for Medicaid, or who are categorically eligible for Medicaid but not included in the eligible target population when those contacts relate directly to the identification and management of the non-eligible or non-targeted individual's needs and care. ~~Individuals receiving the Standard benefit package are not categorically eligible for Medicaid and therefore are not eligible for targeted case management;~~
 - (f) Assisting an individual, who has not yet been determined eligible for Medicaid, to apply for or obtain ~~this~~ eligibility;
 - (g) TCM services provided to an individual if the services are case management services funded by Title IV-E or Title XX of the Social Security Act, or federal or ~~s~~State funded parole and probation, or juvenile justice programs;
 - (h) Activities for which third parties are liable to pay.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-141-0860

Oregon Health Plan^[kg1] Primary Care Manager and Patient Centered Primary Care Home Provider Qualification and Enrollment

(1) Definitions:

(a) ACA-qualified conditions shall ~~will~~ be posted on the agency website. The types of conditions include a mental health condition, substance use disorders, asthma, diabetes, heart disease, BMI over 25 or for patients under the age of 20, the equivalent measure would be BMI equal or greater than 85 percentile, HIV/AIDS, hepatitis, chronic kidney disease and cancer;

(b) An ACA-qualified patient is a patient who meets the criteria described in these rules as authorized by Section 2703 of the Patient Protection and Affordable Care Act.

(c) ACA-qualified patients are individuals with:

(A) A serious mental health condition; or

(B) At least two chronic conditions proposed by the state and approved by CMS; or

(C) One chronic condition and at risk of another qualifying condition as described above;

(i) Providers and plans must ~~are to~~ use information published by the US Preventive Services Task Force, Bright Futures, and HRSA Women's Preventive Services when making decisions about the particular risk factors for an additional chronic condition that may lead a patient with one chronic condition to meet the criteria of one chronic condition and at risk of another.

(ii) The conditions and risk factors shall be documented in the patient's medical record.

(d) Core services are defined as:

(A) Comprehensive Care Management is identifying patients with high risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. Care management activities may include but are not limited to population panel management, defining and following self-management goals, developing goals for preventive and chronic illness care, developing action plans for exacerbations of chronic illnesses, and developing end-of-life care plans when appropriate.

(B) Care coordination is an integral part of the PCPCH. Care coordination functions will include the use of the person centered plan to manage such referrals and monitor follow up as necessary. The Division shall assign clients to a provider, clinic, or team to

increase continuity of care and ensure responsibility for individual client care coordination functions, including but not limited to:

- (i) Tracking ordered tests and notifying all appropriate care-givers and clients of results;
- (ii) Tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to clients and clinicians; and
- (iii) Directly collaborating or co-managing clients with specialty mental health and substance abuse, and providers of services and supports to people with developmental disabilities and people receiving long- term care services and supports. (The Division strongly encourages co-location of behavioral health and primary care services.);

(C) Health promotion is demonstrated when a PCPCH provider supports continuity of care and good health through the development of a treatment relationship with the client, other primary care team members and community providers. The PCPCH provider shall promote the use of evidence-based, culturally sensitive wellness and prevention by linking the client with resources for smoking cessation, diabetes, asthma, self-help resources and other services based on individual needs and preferences. The PCPCH shall use health promotion activities to promote patient and family education and self-management of their ACA-qualifying conditions;

(D) Comprehensive transitional care is demonstrated when a PCPCH emphasizes transitional care with either a written agreement or procedures in place with its usual hospital providers, local practitioners, health facilities and community-based services to ensure notification and coordinated, safe transitions, as well as improve the percentage of patients seen or contacted within one (1) week of facility discharges;

(E) Individual and family support services are demonstrated when a PCPCH has processes in place for:

- (i) Patient and family education;
- (ii) Health promotion and prevention;
- (iii) Self-management supports; and

(iv) Information and assistance to obtain available non-health care community resources, services and supports.

(F) Referral to community and social support services is demonstrated through the PCPCH's processes and capacity for referral to community and social support services, such as patient and family education, health promotion and prevention, and self-management support efforts, including available community resources.

(e) Patient Centered Primary Care Home (PCPCH) pursuant to OAR 409-055-0010(7) is defined as a health care team or clinic as defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to 409-055-0040.

(f) A PCPCH "team" is interdisciplinary and inter-professional and must include non-physician health care professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, community health workers, personal health navigators and peer wellness specialists authorized through State plan or waiver authorities. (*Community health workers, personal health navigators and peer wellness specialists are individuals who meet criteria established by the Oregon Health Authority, have passed criminal history background check, and in the judgment of the Authority, hiring agency, and licensed health professional approving the patient centered plan, have the knowledge, skills, and abilities to safely and adequately provide the services authorized). These PCPCH professionals may operate in a variety of ways, such as free standing, virtual, or based at any of the clinics and facilities. (f) Person-centered plan is defined as the plan that shall be developed by the PCPCH and reflect the client and family/caregiver preferences for education, recovery and self-management as well as management of care coordination functions. Peer supports, support groups and self-care programs shall be utilized to increase the client and caregivers knowledge about the client's health and health-care needs. The person-centered plan shall be based on the needs and desires of the client including at least the following elements:

(A) Options for accessing care;

(B) Information on care planning and care coordination;

(C) Names of other primary care team members when applicable; and

(D) Information on ways the team member participates in this care coordination;

(g) Primary Care Managers (PCM) must be trained and certified or licensed, as applicable under Oregon statutes and administrative rules, in one of the following disciplines:

(A) Doctors of medicine;

(B) Doctors of osteopathy;

(C) Naturopathic physicians;

(D) Nurse Practitioners;

(E) Physician assistants.

(F) Naturopaths who have a written agreement with a physician sufficient to support the provision of primary care, including prescription drugs, and the necessary referrals for hospital care.

(2) Enrollment requirements:

(a) To enroll as a PCM, all applicants must:

(A) Be enrolled as ~~Oregon Division of Medical Assistance Programs~~ (a Division) providers;

(B) Make arrangements to ensure provision of the full range of PCM Managed Services, including prescription drugs and hospital admissions;

(C) Complete and sign the PCM Application (DMAP 3030 (7/11)).

(D) If the Division determines that the PCM or an applicant for enrollment as a PCM does not comply with the OHP administrative rules pertaining to the PCM program or the Division's General Rules, or if the Division determines that the health or welfare of Division clients may be adversely affected or in jeopardy by the PCM the Division may:

(i) Deny the application for enrollment as a PCM;

(ii) Close enrollment with an existing PCM; or

(iii) Transfer the care of those PCM clients enrolled with that PCM until such time as the Division determines that the PCM is in compliance.

(E) The Division may terminate their agreement without prejudice to any obligations or liabilities of either party already accrued prior to termination, except when the obligations or liabilities result from the PCM's failure to terminate care for those PCM members. The PCM shall be solely responsible for its obligations or liabilities after the termination date when the obligations or liabilities result from the PCM's failure to terminate care for those PCM members.

(b) To enroll as a PCPCH with the Division, all applicants must:

(A) Apply to and be "recognized" as a PCPCH by the Oregon Health Authority (Authority) as organized in accordance with relevant Oregon Office of Health Policy and Research (OHPR) administrative rules (OAR 409-055-0000 to 409-055-0090), the Division administrative rules (chapter 410, division 141), and OHPR's Oregon Patient Centered Primary Care Home Model, dated October 2011 and found at www.primarycarehome.oregon.gov. The Authority grants PCPCH recognition only when a practice, site, clinic, or individual provider is successful in the application process with the Authority;

(i) The type of practice, site, clinic or individual provider that may apply to become a PCPCH, include physicians (family practice, general practice, pediatricians, gynecologists, obstetricians, Internal Medicine), Certified Nurse Practitioner and Physician Assistants, clinical practices or clinical group practices; FQHCs; RHCs; Tribal clinics; Community health centers; Community Mental Health Programs and Drug and Alcohol Treatment Programs with integrated Primary Care Providers.

(ii) PCPCH services will occur under the direction of licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, or professional counselors.

(B) PCPCH providers must complete the enrollment process in order to receive reimbursement (OAR 410-120-1260), except as otherwise stated in OAR 410-120-1295. The Provider Enrollment Attachment (attachment to the Provider Enrollment Agreement) sets forth the relationship between the Division and the PCPCH site (recognized clinic or provider) to receive payment for providing PCPCH services under OHP OAR 410-141-0860.

(C) New PCPCH enrollment shall be effective on or after October 1, 2011 or the date established by the Division upon receipt of required information. (Note: PCPCH tier enrollment changes shall be effective the first of the next month or a date approved by the Division).

(D) The PCPCH enrollment process requires the PCPCH submit a list of fee-for-service (FFS) clients to the Division in a format approved by the Division. The PCPCH must identify current OHP clients being treated within their practice. The PCPCH shall identify that patients are ACA qualified or not as defined in these rules.

(E) PCPCHs serving clients enrolled in a managed care organization (MCO, FCHP or PCO) must consult the MCO on the procedures for developing an OHP client list. The MCO shall submit the list of their identified clients to the Division. Identified client lists are submitted to the Division so that the Division can assign the appropriate clients to the PCPCH and begin making payments for services rendered, all in accordance with relevant OARs.

(F) Termination of PCPCH enrollment shall be the date established by the Authority. All providers shall comply with Provider Sanctions as outlined in OAR 410-120-1400.

(3) ~~Payment:~~ The Division shall make per member per month (PMPM) payments based on the PCPCH clinic's recognized tier and on the patient's ACA status.

(a) PCPCH payments are made as follows:

(A) For fee-for-service (FFS) ACA-qualified patients, the amount of the PMPM shall be based on the PCPCH tier:

- (i) \$ 10 for tier 1;
- (ii) \$15 for tier 2 and;
- (iii) \$24 for tier 3.

(B) For FFS non-ACA-qualified patients, the amount of the PMPM shall be based on the PCPCH tier:

- (i) \$2 for tier 1;
- (ii) \$4 for tier 2 and;
- (iii) \$6 for tier 3.

(b) For MCO enrolled ACA-qualified members MCO's are responsible for payment to PCPCH providers assigned to the PCPCH. MCOs shall make payments to PCPCH clinics in accordance with OAR 409-055-0030. If an MCO retains any portion of the PCPCH payment, that portion shall be used to carry out functions related to PCPCH and is subject to approval and oversight by the Division.

(c) MCOs that wish to use PCPCH payment methodology ~~and/or~~ amount different than Division must receive Division approval

(d) The Division shall not provide additional PMPM payment to the MCOs for non-ACA-qualified members. For MCO enrolled non-ACA-qualified members PCPCH payment responsibility will be integrated into MCOs capitation payments and covered services at the next opportunity to revise capitation rates expected on or near July 1, 2012.

(e) MCOs must use an alternative payment methodology that supports the Division's goal of improving the efficiency and quality of health services for primary care homes by decreasing the use of FFS reimbursement models. PMPM payment is an alternative methodology.

(f) It is the Division's intention that the PCPCH Program will not duplicate other similar services or programs such as PCM and medical case management, and the Authority shall not make PCPCH payments for patients who participate in these programs. The Division may review on a program to program basis if care coordination programs are complimentary with PCPCH.

(4) Client Assignment:

(a) OHP clients' participation with PCPCH is voluntary. OHP clients can opt-out at any time from a PCPCH.

(b) The Division will provide client notice of PCPCH assignment including information about benefits of PCPCH and how to notify the Division if they wish to opt out.

(c) The Division shall remove PCPCH assignment from clients who choose not to participate in a PCPCH Program.

(d) Upon completion of PCPCH enrollment process and approval from CMS, the Division will implement PMPM payments for non-ACA patients who are not enrolled in an FCHP or PCO. The Division ~~shall~~ will integrate this service into rate setting and managed care responsibilities at the first available opportunity. This provision only affects the startup phase of the program and is acknowledgment of a more gradual implementation than was originally intended;

(e) Clients assigned must have full medical eligibility with either Oregon Health Plan (OHP) Plus (BMH, BMP, BMM or BMD) ~~or OHP Standard (KIT)~~ benefit plans, this excludes CAWEM Plus (CWX) and QMB (MED) only.

(5) Documentation Requirements:

(a) The PCPCH must coordinate the care of all assigned clients who do not choose to opt out of the PCPCH Program, to ensure they have a “person-centered plan” that has been developed with the client or the client’s caregiver. The PCPCH must provide an assigned client with at least one of the six “core” services as defined in Oregon State Medicaid Plan, each quarter and document the service(s) in the medical record in order to be eligible for payment.

(b) PCPCHs shall assure that the patient’s engagement, education and agreement to participate in the PCPCH program are documented within six months of initial participation;

(c) PCPCHs shall assure that for each patient, providers are working with the patient to develop a person-centered plan within six months of initial participation and revise as needed;

(d) For ACA-qualified patients, PCPCH clinics shall provide one of the six core services or an activity that is defined in the service definition at least quarterly. Documentation of the services provided must be kept in the patient’s medical record;

(e) PCPCHs shall assure that they notify the Division when a patient moves out of the service area, terminates care, or no longer receives primary care from the PCPCH clinic as stated in OAR 410-141-0080 and 410-141-0120. Patient assignment shall be terminated at the end of the month for which PCPCH services terminated, unless a move to another PCPCH provider begins primary care before the end of the month. In this situation, the disenrollment and payment will be prorated;

(f) PCPCH clinics and MCOs must report to the Division a complete list of their Medicaid PCPCH patients, no less than quarterly. The Division will not make payments for patients that are not reported on these quarterly reports or for patients where documentation requirements are not met; PCPCH clinics and MCOs may provide the Division information on new member assignment or termination member assignment on a more frequent basis if they desire;

(g) PCPCH clinics must log on to the PCPCH provider portal, which will be available at www.primarycarehome.oregon.gov, no less than quarterly. In conjunction with submission of the quarterly patient list, logging on to the PCPCH provider portal serves as evidence that the clinic has complied with the service and documentation requirements. Clinics will have the opportunity to track quality measures through the portal and use this as a panel management tool;

(h) PCPCH clinics that have their own information technology system can use their own system as an alternative to the PCPCH provider portal. To do this, PCPCH clinics must:

(A) Be able to document quarterly usage of the system for panel management purposes; and

(B) Submit a request in writing to the Division to utilize their system as an alternative. The Division will respond to each request in writing.

(i) ~~MCOs~~, No later than the 15th of January, April, July and October, MCO's shall provide the Division with the following information for the preceding quarter:

(A) Number of clinics or sites that meet PCPCH standards;

(B) Number of Primary Care Providers in those service delivery sites;

(C) Number of patients receiving primary care in those sites; and

(D) Number of ACA-qualified patients receiving primary care at those sites

(j) PCPCH shall provide their Division PCPCH clinic number when referring a patient to another provider to ensure it is added to the claim as a referring provider. The PCPCH will also need to document the referral in the patient's medical record.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 413.042, 414.065;
Stats. Implemented: ORS 414.065

410-142-0040 Eligibility for the Hospice Services

(1) Hospice services are covered for clients who have:

- (a) Been certified as terminally ill in accordance with OAR 410-142_0060, and;
- (b) Oregon Health Plan (OHP) Plus ~~or OHP Standard~~ benefit package coverage.

(2) Providers must bill Medicare for hospice services for clients with Medicare Part A coverage. Medicare's payment is considered payment in full.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

DIVISION OF MEDICAL ASSISTANCE PROGRAMS

OAR's being repealed in 2014

410-122-0055

~~OHP Standard Benefit Package Limitations~~

~~(1) The Division of Medical Assistance Programs (Division) limits coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for the Oregon Health Plan (OHP) Standard benefit package to the codes referenced in Table 122-0055 below. Coverage requirements and limitations, as specified in chapter 410, division 122, apply. For more information about the OHP Standard benefit package, see the Division's General Rules (chapter 410, division 120).~~

~~(2) Table 122-0055~~

~~[ED. NOTE: Tables referenced are not included in rule text. Click here for PDF copy of table(s).]~~

~~Stat. Auth.: ORS 413.042 & 414.065~~

~~Stats. Implemented: ORS 414.065~~

410-123-1670

~~OHP Standard Limited Emergency Dental Benefit~~

~~(1) The Oregon Health Plan (OHP) Standard Limited Emergency Dental benefit is intended to provide services requiring immediate treatment and is not intended to restore teeth.~~

~~(2) Refer to the "Covered and Non-Covered Dental Services" document. See OAR 410-123-1220. Procedures listed as "Yes" for the OHP Standard Benefit Package in the Covered and Non-Covered Dental Services document are covered but are limited to treatment for conditions such as:~~

~~(a) Acute infection;~~

~~(b) Acute abscesses;~~

~~(c) Severe tooth pain;~~

~~(d) Tooth re-implantation when clinically appropriate; and~~

~~(e) Extraction of teeth, limited only to those teeth that are symptomatic.~~

~~(3) Hospital Dentistry is not a covered benefit for the OHP Standard population, with the following exceptions:~~

~~(a) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia (or IV conscious sedation, if appropriate); or~~

~~(b) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia (or IV conscious sedation, if appropriate).~~

~~(4) Any limitations or prior authorization requirements on services listed in OAR 410-123-1260 or 410-123-1160 will also apply to services in the OHP Standard benefit.~~

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-125-0047

Limited Hospital Benefit for the OHP Standard Population

~~(1) The Oregon Health Plan (OHP) Standard population has a limited hospital benefit for urgent or emergent inpatient and outpatient services. Inpatient and outpatient hospital services are limited to the International Classification of Diseases 9th revision Clinical Modification (ICD-9-CM) Diagnoses codes listed on the 'Standard Population Limited Hospital Benefit Code List.'~~

~~(2) The limited hospital benefit includes the ICD-9-CM codes listed in the OHP Standard Population—Limited Hospital Benefit Code List. This rule incorporates by reference the OHP Standard Population—Limited Hospital Benefit Code List. This list includes diagnoses requiring prior authorization indicated by the letters for prior authorization (PA) next to the code number. The archived and the current list is available on the web site (www.dhs.state.or.us/policy/healthplan/guides/hospital), or contact the Division of Medical Assistance Programs (Division) for a hardcopy. The document dated:~~

~~(a) August 1, 2004, is effective for dates of service August 1, 2004 through August 31, 2004;~~

~~(b) September 1, 2004, is effective for dates of service September 30, 2004 through June 30, 2008; and~~

~~(c) July 1, 2008 is effective for dates of service July 1, 2008 forward;~~

~~(d) On or after January 1, 2012 the limited hospital benefit for the OHP Standard population will be enhanced to the OHP plus hospital benefit and will not be operative until the Division determines all necessary federal approvals have been obtained.~~

~~(3) The Division shall reimburse hospitals for inpatient (diagnostic and treatment) services, outpatient (diagnostic and treatment services) and emergency room (diagnostic and treatment) based on the following:~~

~~(a) For treatment, the diagnosis must be listed in the OHP Standard Population—Limited Hospital Benefit Code List;~~

~~(b) For treatment the diagnosis must be above the funding line on The Health Services Commission Prioritized List of Health Services (OAR 410-141-0520);~~

~~(c) The diagnosis (ICD-9) must pair with the treatment (CPT code); and~~

~~(d) Prior authorization (PA) must be obtained for codes indicated in the OHP Standard Population—Limited Hospital Benefit Code List. PA request should be directed to the Division and will follow the present (current) PA process. PAs must be processed as expeditiously as the client's health condition requires;~~

~~(e) Medically appropriate services required to make a definitive diagnosis are a covered benefit.~~

~~(4) Some non-diagnostic outpatient hospital services (e.g. speech, physical or occupational therapy, etc.) are not covered benefits for the OHP Standard population (see the individual program for coverage) in the hospital setting.~~

~~(5) For benefit implementation process and PA requirements for the client enrolled in a Fully Capitated Health Plan (FCHP) and/or Mental Health Organization (MHO), contact the client's FCHP or MHO. The FCHP and/or MHO may have different requirements than the Division.~~

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

410-127-0050

Client Copayments

Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 409.040 & 413.042
Stats. Implemented: ORS 414.065

410-129-0195

Standard Benefit Package

(1) Hearing aids, hearing aid repairs, and examinations and audiological diagnostic services only performed to determine the need for or the appropriate type of hearing aid(s) are not covered under the Standard Benefit Package.

(2) Diagnostic testing, including hearing and balance assessment services, performed by an audiologist is covered under the Standard Benefit Package when a physician orders testing to obtain information as part of the physician's diagnostic evaluation, or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem. Audiological diagnostic services are not covered under the Standard Benefit Package when the diagnostic information required to determine the appropriate medical or surgical treatment is already known to the physician, or the diagnostic services are performed only to determine the need for or the appropriate type of hearing aid.

(3) Speech language pathology services are not covered under the Standard Benefit Package.

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

410-130-0163

Standard Benefit Package

(1) The Division of Medical Assistance Programs (Division) does not cover some services under the Standard Benefit Package. Refer to General Rule 410-120-1210 for restrictions in other programs.

(2) The Division covers medical supplies and equipment only when applied by the practitioner in the office setting for treatment of the acute medical condition. Durable medical equipment (DME) and medical supplies dispensed by DME providers are limited. Refer to DMEPOS rule 410-122-0055 for specific information on coverage.

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

410-132-0055

OHP Standard Benefit Package

(1) Private duty nursing services are not covered for clients receiving the Standard Benefit Package. See Division General Rules, OAR 410-120-1210 for additional information.

(2) The Oregon Health Plan Standard Benefit Package includes limited home-enteral/parenteral services and intravenous services (see OAR 410-148-0090).

Stat. Auth.: ORS 409.040 & 413.042

Stats. Implemented: ORS 414.065

410-146-0022

OHP Standard Benefit for American Indian/Alaska Native Clients

Once the Division of Medical Assistance Programs (Division) receives authorization to implement SB 878 from the Centers for Medicare and Medicaid Services, OHP Standard AI/AN clients have the following benefits:

(1) AI/AN clients eligible for the OHP Standard Benefit are allowed by the authority of SB 878 to receive all services allowed under the OHP Plus Benefit that are reimbursed by CMS at 100% FPL;

(2) AI/AN clients eligible for the OHP Standard Benefit do not change eligibility group unless allowed by OAR. For example OHP Standard female client becomes pregnant and moves into OHP Plus during pregnancy;

(3) Excluded services: Transportation.

Stat. Auth.: ORS 413.042, 414.065 & 430.010

Stats. Implemented: ORS 414.065 & 414.428

Hist.: OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03

410-146-0380

Oregon Health Plan Standard Emergency Dental Benefit

(1) Clients with the OHP Standard benefit package have a limited dental benefit. The intent of the OHP Standard emergency dental benefit is to provide services requiring immediate treatment and is not intended to restore teeth. Services are limited to the treatment of conditions listed in Oregon Administrative Rule (OAR) 410-123-1670(2) OHP Standard Limited Emergency Dental Benefit.

(2) Hospital dentistry is not a covered benefit for the OHP Standard population, except for clients specified in OAR 410-123-1670(3).

(3) Dental services for the OHP standard population are limited to those procedures listed in the covered and non-covered dental services document. Refer to the document in effect for the date the dental service was furnished, found at website <http://www.dhs.state.or.us/policy/healthplan/guides/dental/main.html> — Refer to OAR 410-123-1670(2).

(4) Any limitations or prior authorization requirements for services listed in OARs 410-123-1160 and 410-123-1260 will also apply to services in the OHP Standard benefit when provided by an AI/AN provider.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-147-0125

OHP Standard Emergency Dental Benefit

(1) Clients with the Oregon Health Plan (OHP) Standard benefit package have a limited dental benefit. The intent of the OHP Standard Emergency Dental benefit is to provide services requiring immediate treatment and is not intended

to restore teeth. Services are limited to the treatment of conditions listed in Oregon Administrative Rule (OAR) 410-123-1670(2).

(2) Hospital Dentistry is not a covered benefit for the OHP Standard population, except for clients specified in OAR 410-123-1670(3).

(3) Dental services for the OHP standard population are limited to those procedures listed in the Covered and Non-Covered Dental Services document. Refer to the document in effect for the date the dental service was furnished, found at website <http://www.dhs.state.or.us/policy/healthplan/guides/dental/main.html> Refer to OAR 410-123-1670(2).

(4) Any limitations or prior authorization requirements for services listed in OARs 410-123-1160 and 410-123-1260 will also apply to services in the OHP Standard benefit when provided by an FQHC or RHC.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-148-0090

Standard Benefit Package

(1) Some procedure codes/services are not covered for the Standard Benefit Package population. See General Rules 410-120-1210 for additional information.

(2) The OHP Standard benefit package includes limited home enteral/parenteral and IV services:

(a) Drugs that are usually self-administered by the patient such as oral pill form or self-injected medications, are not covered;

(b) Oral nutrition services and supplies are not covered, except when the nutritional supplement meets the criteria specified in 410-148-0260(3), and is the sole source of nutrition for the client;

(c) Nursing assessment and nursing visits must be directly related to administration of the home enteral/parenteral nutrition and intravenous services pursuant to Oregon's Nurse Practices Act (OAR 851-001-0000). Home health and private duty nursing are not covered services under the Standard benefit package (General Rules 410-120-1210), except nursing assessment and nursing visits under this limited Home Enteral/Parenteral and IV benefit are covered.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065