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PERMANENT ADMINISTRATIVE RULES

Oregon Health Authority, Division of Medical Assistance
Programs

410

Agency and Division

Administrative Rules Chapter Number

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RULE CAPTION

Allow Use of Medical Billing Codes Designated for Adaptive Behavior Assessment
and Treatment Services

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND: 410-130-0160

REPEAL: 410-130-0160 (T)

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 413.042

Other Auth.:

Stats. Implemented: ORS 414.025, 414.065

RULE SUMMARY

This rule directs medical providers to use billing codes following national standards and identifies which code sets are appropriate. One aspect of the current rule prevents use of Category III CPT Codes - a code set designated for

services or technologies that are new and need to be tracked for data collection. The Division has identified that the billing codes for Adaptive Behavior Assessment and Treatment services found within the Category III CPT Code set are the most appropriate codes to use for billing ABA therapy. This rule change will allow use of these ABA therapy related billing codes. It will continue to restrict use of the remaining Category III codes.



Authorized Signer

DAVID SUMMIT

Printed Name

3/27/2015

Date

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410-130-0160

Codes

(1) ICD-CM Diagnosis Codes:

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

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

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

(2) CPT and HCPCS Codes:

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

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

(c) CPT category II (codes with fifth character of "F") and CPT category III codes (codes with fifth character "T") are not Division of Medical Assistance Programs' (Division) covered services, with the exception of the Category III codes included under the following headings: Adaptive Behavior Assessments, Adaptive Behavior Treatment, and Exposure Adaptive Behavior Treatment with Protocol Modification;

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

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

(4) For determining the appropriate level of service code for Evaluation and Management services, read the definitions in the CPT codebook. Use the CPT guidelines to verify the level of service, especially for office visits. Unless otherwise

specified in the Medical-Surgical provider rule, use the guidelines from CPT and HCPCS.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065