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March 2004

To: OMAP Medical-Surgical Providers

From: Joan M. Kapowich, Manage
OMAP Program and Policy

Re: Medical-Surgical Services Administrative Rules,
Rulebook Revision 2

Effective: **April 1, 2004**

OMAP amended the following Rules for technical changes to clarify policy:
OAR 410-130-0000, 410-130-0180, 410-130-0200, 410-130-0220, 410-130-0240, 410-130-0255, 410-130-0585, 410-130-0587, 410-130-0680, and 410-130-0700.

If you are reading this letter on OMAP's website: (http://www.dhs.state.or.us/policy/healthplan/rules/), this Administrative rulebook contains a complete set of rules for this program, including the above revisions.

If you receive hardcopy of revisions, this letter is attached to the revised rules to be used as replacements in your rulebook.

If you have billing questions, contact a Provider Services Representative toll-free at 1-800-336-6016 or direct at 503-378-3697.

TR 529 4-04

DEPARTMENT OF HUMAN SERVICES, DEPARTMENTAL ADMINISTRATION AND MEDICAL ASSISTANCE PROGRAMS

DIVISION 130

MEDICAL- SURGICAL SERVICES

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410-130-0000 Foreword

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

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

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Podiatrists;

(c) Acupuncturists;

(d) Licensed Physician assistants;

(e) Nurse practitioners;

(f) Laboratories;

(g) Family planning clinics;

(h) Social workers (only maternity case management);

(i) Licensed Direct entry midwives;

(j) Portable x-ray providers;

(k) Ambulatory surgical centers;

(l) Chiropractors;

(m) Nutritionists (only maternity case management);

(n) Licensed Dieticians (only maternity case management);

(o) Registered Nurse First Assistants;

(p) Certified Nurse Anesthetists.

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

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

(5) The Health Services Commission's Prioritized List of Health Services is found at website http://www.ohpr.state.or.us/hsc/index hsc.htm.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

410-130-0010 Health Insurance Claim Form (CMS-1500)

(1) Each CMS-1500 is a complete billing document. If there is not enough space on the CMS-1500 to bill all procedures provided on the same date of service, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one CMS-1500 to another.

(2) Bill prior authorized services on a separate CMS-1500 form for services not requiring prior authorization.

(3) Each field described in detail in section (6) of this rule is required unless otherwise noted.

(4) Send completed CMS-1500 forms to the Office of Medical Assistance Programs (OMAP).

(5) OMAP does not supply CMS-1500 forms, they can be obtained through local business forms suppliers or the Oregon Medical Association.

(6) Instructions for completing the CMS-1500:

(a) 1a -- The eight-digit number found on the OMAP Medical Care ID;

(b) 2 -- The name as it appears on the OMAP Medical Care ID;

(c) 9 (required when applicable) -- This information is listed on the OMAP Medical Care ID. When appropriate, use the Third-Party Resource (TPR) codes found in the Billing Section of the Medical-Surgical Services guide to indicate response received from other resources;

(d) 10a-c (required when applicable) -- Complete as appropriate when an injury is involved;

(e) 10d (required when applicable) -- Put a "Y" in this field if service was an emergency. Labor and delivery services for Citizen/Alien-Waived Emergency Medical (CAWEM) women are considered an emergency;

(f) 17 -- Enter the name of the referring provider;

(g) 17a -- Enter the OMAP provider number of the referring provider;

(h) 21 -- Enter the principal diagnosis code first and subsequent diagnosis as needed. Use diagnosis codes from ICD-9-CM. Enter up to four codes in priority

order. Carry the codes to their highest degree of specificity (fourth or fifth digit). No diagnosis is required for independent labs or portable X-ray providers;

(i) 23 (required when applicable) -- If required, enter the nine-digit prior authorization number here;

(j) 24A -- Must be numeric. If "From-To" dates are used, all services must have been provided on consecutive days;

(k) 24B -- Where service was provided:

(A) 1 -- Inpatient hospital;

(B) 2 -- Outpatient hospital;

(C) 3 -- Practitioner's office;

(D) 4 -- Client's home;

(E) 5 -- Day care facility;

(F) 6 -- Night care facility;

(G) 7 -- Intermediate care facility;

(H) 8 -- Skilled nursing home;

(I) 9 -- Surgical procedures -- emergent;

(J) A -- Independent lab;

(K) B -- Other medical/surgical facilities/Ambulatory Surgical Centers;

(L) C -- Residential treatment center;

(M) D -- Specialized treatment center.

(l) 24C -- Type of Service Codes (TOS):

(A) 1 -- Medical care -- 90000-99999 MDs, DOs and Naturopaths;

(B) 2 -- Primary Surgeon -- 10000-69999 MDs, DOs and Naturopaths;

(C) 7 -- Anesthesia -- MDs, DOs and CRNAs;

(D) 8 -- Assistant Surgeon -- 10000-60000;

(E) H -- Ambulatory Surgical Centers and Birthing Centers;

(F) K -- Lab/X-ray (professional & technical) 70000-80000 -- all providers;

(G) L -- Podiatrist;

(H) N -- Nurse Practitioner -- Registered Nurse First Assistant;

(I) P -- Lab/X-ray Professional fee charge, charge only for lab or X-ray service -- 70000-80000 -- all providers;

(J) S -- Acupuncturists, Chiropractors, Psychologists, Licensed Direct Entry Midwives. Maternity Case Management services only: RN, Dietary Counselor, Licensed Dietician and Social Worker;

(K) T -- Lab/X-ray -- Technical fee charge only for laboratory or X-ray service -- 70000-80000 -- all providers;

(L) V -- Family planning clinics;

(M) W -- Licensed Physician Assistant -- Use primary physician's provider number.

(m) 24D -- Use only CPT, HCPCS or OMAP unique codes. When appropriate, also enter no more than one two-digit modifier;

(n) 24E -- Use the one-digit line reference number from Field 21;

(o) 24F -- Enter a charge for each line item;

(p) 24G -- This number must match the number of days in Field 24A or the number of units of services provided;

(q) 24H -- Enter a "Y" only if the service is related to family planning or EPSDT;

(r) 24K (required when applicable) -- Enter the OMAP performing provider number here if a billing provider number is used in Field 33;

(s) 26 (optional) -- If your patient account number is entered here, OMAP will print the account number on the Remittance Advice;

(t) 28 -- Enter the total amount for all charges listed on this CMS-1500;

(u) 29 (required when applicable) -- Enter the total amount paid by any other insurance or resource. Do not include OMAP copayments in this field. Do not show any payment from OMAP on this line. If the client has other insurance and this amount is zero, there must be a two-digit "reason" code in Field 9;

(v) 30 -- Enter the balance after subtracting the Amount Paid from the Total Charge;

(w) 33 -- Enter the OMAP provider number of the provider to whom the check should be sent (actual service provider or the provider's billing service).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-014-0530; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 48-1991, f. 10-16-91, cert. ef. 11-1-91; HR 12-1992, f. & cert. ef. 4-1-92; HR 36-1992, f. & cert. ef. 12-1-92; HR 6-1994, f. & cert. ef. 2-1-94; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 82-2002, f. 12-24-02, cert. ef. 1-1-03

410-130-0020 Medicare/Medical Assistance Program Claims

(1) If a client has both Medicare and Medical Assistance Program coverage, providers must bill Medicare first. Medicare will automatically forward all claims to the Office of Medical Assistance Programs (OMAP) for processing.

(2) If Medicare transmits incorrect information to OMAP, or if an out-of-state Medicare carrier or intermediary was billed, providers must bill OMAP using an OMAP 505 form. Enter any Medicare payment received in the "Amount Paid" field or use the appropriate Third Party Resource (TPR) explanation code in the "Other Health Insurance Coverage" portion of the OMAP 505 form.

(3) If any payment is made by OMAP, an Adjustment Request must be submitted to correct payment, if necessary. OMAP payment will be the lesser of Medicare's maximum allowable rate or OMAP's maximum allowable rate.

(4) Send all completed OMAP 505 forms to OMAP.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-014-0540; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00

410-130-0040 Instructions on How to Complete the OMAP 505

(1) 1 -- Enter the client's name as printed on the Office of Medical Assistance Programs (OMAP) Medical Care ID.

(2) 6 -- Enter the eight-digit number found on the OMAP Medical Care ID.

(3) 8 -- Enter the Medicare number as it appears on the client's Medicare Identification Card.

(4) 9 (required when applicable) -- If no payment was received from Medicare, use this space to explain why no payment was made. Select a two-digit "reason" code from the Third Party Resource (TPR) codes shown in the Medical-Surgical Services guide. Be sure that this "reason" code is the first entry in Field 9, followed by the name of the TPR (Medicare). Example: Medicare paid nothing ("reason" code NC, Not Covered). Enter: NC-Medicare. If there is any other TPR, be sure to use a code that shows what both insurances did.

(5) 10 (required when applicable) -- Complete only when an injury is involved.

(6) 16A (required when applicable) -- Complete if the service was performed as an emergency. Labor and delivery services for Citizen/Alien-Waived Emergency Medical (CAWEM) women are considered an emergency.

(7) 19 -- Enter the OMAP provider number or UPIN of the referring (requesting) practitioner.

(8) 23A -- Enter primary diagnosis/condition of the client indicated by appropriate ICD-9-CM code number. Enter up to four codes in priority order. Carry the codes out to their highest degree of specificity.

(9) 23B -- If the service requires prior authorization, enter the nine-digit Prior Authorization number issued by OMAP or the branch/unit shown on the Medical Care ID.

(10) 24A -- Use a six-digit numeric date. If a "From-To" range is used, all services must be on consecutive days and the quantity in Field 24E must equal the number of days.

(11) 24B -- Enter where service was provided:

(a) 1 -- Inpatient hospital;

(b) 2 -- Outpatient hospital;

(c) 3 -- Practitioner's office;

(d) 4 -- Client's home;

(e) 5 -- Day care facility;

(f) 6 -- Night care facility;

(g) 7 -- Intermediate care facility;

(h) 8 -- Skilled nursing home;

(i) 9 -- Surgical procedures -- emergent;

(j) A -- Independent lab;

(k) B -- Other medical/surgical facility/Ambulatory Surgical Centers;

(l) C -- Residential treatment center;

(m) D -- Specialized treatment center.

(12) 24C -- Enter the appropriate procedure code plus any appropriate two-digit modifier.

(13) 24D -- Enter a single diagnosis reference number on each line as shown in Field 23A.

(14) 24E -- Enter the number of services or units you are billing for.

(15) 24F -- Enter the appropriate type of service:

(a) 1 -- Medical care -- 90000-99999 MDs, DOs and Naturopaths;

(b) 2 -- Primary Surgeon -- 10000-69999 MDs, DOs and Naturopaths;

(c) 7 -- Anesthesia -- MDs, DOs and CRNAs;

(d) 8 -- Assistant Surgeon -- 10000-60000;

(e) H -- Ambulatory surgical centers and birthing centers;

(f) K -- Lab/X-ray (prof & tech) -- 70000-80000 -- all providers;

(g) L -- Podiatrist;

(h) N -- Nurse Practitioner -- Registered Nurse First Assistant;

(i) P -- Lab/X-ray Professional fee charge, charge only for lab or X-ray service -- 70000-80000 -- all providers;

(j) S -- Acupuncturists, Chiropractors, Psychologists, Licensed Direct Entry Midwives. Maternity Case Management services only: RN, Dietary Counselor, Licensed Dietician and Social Worker;

(k) T -- Lab/X-ray -- Technical fee charge only for laboratory or X-ray service -- 70000-80000 -- all providers;

(l) V -- Family planning clinics;

(m) W -- Licensed Physician Assistant -- Use primary physician's provider number.

(16) 24G -- Enter the total dollar amount billed to Medicare for each service.

(17) 24H -- Enter the dollar amount allowed by Medicare for each service.

(18) 24I -- Enter your OMAP performing provider number here if it is not used in Field 34.

(19) 27 -- Add the charges in Field 24G and enter the total dollar amount Medicare was billed.

(20) 28 -- Enter the total dollar amount paid by Medicare for the services. Do not show Medicare or other insurance write-offs.

(21) 30 (required when applicable) -- Enter any amount paid by any health insurance resource, other than Medicare. Do not include OMAP copayments in this field. If the amount is zero, put in a "0".

(22) 31 -- Subtract the amounts in Field 28 and 30 from Field 27 and enter the balance in this field. You must enter an amount in this field.

(23) 32 (optional) -- If your patient account number is entered here, OMAP will print the account number on the Remittance Advice.

(24) 34 -- Enter the OMAP provider number of the actual service provider or the provider's billing service.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-014-0550; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 36-1992, f. & cert. ef. 12-1-92; HR 6-1994, f. & cert. ef. 2-1-94; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 83-2002, f. 12-24-02, cert. ef. 1-1-03

410-130-0160 Codes

(1) ICD-9-CM Diagnosis Codes:

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

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

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

(2) CPT, and HCPCS Codes:

(a) Use only codes from the current year for CPT and HCPCS codes.. For services provided between January 1, and March 31, use the previous year or the new codes effective January 1 of a given year;

(b) A grace period from January1st through March 31st of the next year is allowed for codes deleted January 1st. During this grace period, do not use both a current and new code for the same service;

(c) CPT category III codes (codes with fifth digit “T”) are not Medical Assistance Program covered services;

(3) The Medical-Surgical Service rules list the 2003 HCPCS/CPT codes that require authorization, or have limitations. The Health Services Commission’s Prioritized List of Health Services (rule 410-141-0520) determines covered services. (4) 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 would be duplicate billing.

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

(6) Must submit all claims either electronically or paper using CMS 1500 claim form. For claim form(s) and modifier requirements— See the Medical-Surgical Services section in the billing instructions;

(7) For multiple surgical procedures for the same CPT code in the 19000-69999 CPT series bill each on separate lines with different billed amounts. For example, bill CPT 26135 on one line for $290.00 then on second line bill CPT 26135 with $289.99. This includes bilateral procedures.

(8) Bundled Services — Reimbursements for some services are “bundled” into the payment for another service (e.g., payment for obtaining a PAP smear is bundled into the payment for the office visit). Bundled services cannot be billed separately to OMAP or the client. The abbreviation “BND” in the code lists in the OMAP Medical-Surgical Services provider rule indicates the procedure is bundled into another one.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
October 1, 2003

410-130-0165 Client Copayments

(1) OHP Plus:

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

(2) OHP Standard:

(a) A client receiving the OHP Standard Benefit Package may be subject to copayments for Medical-Surgical services. See General Rules, 410-120-1235 for additional information;

(b) For procedure codes where there are both professional (modifier-26) and technical components (modifier-TC), there is a copayment for the technical component only if two different providers are billing for each component. There is no copayment for the professional component alone. The copayment applies only to the technical service. If the same provider performs both professional and technical components, the copayment applies.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
October 1, 2003

410-130-0180 Drugs

(1) Not covered services include:

(a) Laetrile;

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

(c) DMSO, except for instillation into the urinary bladder for symptomatic relief of interstitial cystitis. This service does not require prior authorization;

(d) Infertility drugs.

(2) Drug Administration. Reimbursement is limited to drugs administered by the prescribing practitioner in the office, clinic or home settings. Drugs for self-administration by the client are not billable, EXCEPT contraceptives such as birth control pills, spermicides and patches:

(a) Use an appropriate CPT therapeutic injection code for administration of injections;

(b) Use an appropriate HCPCS code for the specific drug. Do not bill for drugs under code 99070;

(c) When billing unclassified drugs and other drug codes listed below, bill at acquisition cost (purchase price plus postage) and use the following codes:

(A) J1815-J1816;

(B) J3490;

(C) J7699;

(D) J7799;

(E) J8499;

(F) J9999;

(G) Include the name of the drug, NDC number, and dosage.

(d) Epoetin Alpha (EPO) HCPCS are covered;

(e) Do not bill for local anesthetics. Reimbursement is included in the payment for the tray and/or procedure.

(3) For Not Covered/Bundled services or Prior Authorization Requirements refer to OAR 410-130-0200 Table 130-0200-1 and OAR 410-130-0220 Table 130-0220-1.

(4) Follow criteria outlined in the following:

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

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

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

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

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

(f) Participation in Medicaid's Prudent Pharmaceutical Purchasing Program -- OAR 410-121-0157.

(5) Clozapine Therapy:

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

(b) Clozapine Supervision is the management and record keeping of Clozapine dispensing as required by the manufacturer of Clozapine:

(A) Providers billing for Clozapine supervision must document all of the following:

(i) Exact date and results of White Blood Counts (WBC), upon initiation of therapy and at recommended intervals per the drug labeling;

(ii) Notations of current dosage and change in dosage;

(iii) Evidence of an evaluation at intervals recommended per the drug labeling requirements approved by the FDA;

(iv) Dates provider sent required information to manufacturer.

(B) Only one provider (either a physician or pharmacist) may bill per week per client;

(C) Limited to five units per 30 days per client;

(D) Use code 90862 with modifier TC to bill for Clozapine supervision.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

410-130-0190 Tobacco Cessation

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

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

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

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

(c) Assess -- willingness to attempt to quit using tobacco within 30 days;

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

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

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

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

(5) When billing for tobacco cessation counseling use G9016 and for tobacco cessation treatment use S9075.

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

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

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

(c) Individual or group counseling.

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

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

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

(c) Proper documentation of the service must be entered in the client's chart;

(d) One or two telephone calls associated with basic tobacco cessation services may also be appropriate. The same guidelines for supervision and documentation apply.

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

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

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

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
October 1, 2003

410-130-0200 Prior Authorization

(1) If the client is covered by a managed care plan, contact the appropriate managed care plan for prior authorization (PA) requirements and instructions for billing the plan.

(2) If the client has both Medicare and Medical Assistance Program coverage, PA is not required from OMAP for services covered by Medicare, except for most transplants.

(3) Kidney and cornea transplants do not require PA unless they are performed out-of-state.

(4) Contact the Office of Medical Assistance Programs (OMAP) Medical Director's Office for PA for transplants other than kidney and cornea, and requests for non-emergent, non-urgent out-of-state services. Refer to the OMAP Transplant Services rule for further information on transplants and refer to the General Rules for further information concerning out-of-state services.

(5) Services for clients of the Medically Fragile Children's Unit must be authorized by that Unit.

(6) For clients enrolled in the fee-for-service (FFS) High Risk Medical Case Managed program, contact the Case Management Contractor shown on the client’s Medical Care ID. See the Medical-Surgical Services Supplemental Information guide for details.

(7) All other procedures listed in the Medical-Surgical Services provider rule with a PA indicator must be prior authorized by the Oregon Medical Professional Review Organization (OMPRO) when performed in any setting. A second opinion may be requested by OMAP or OMPRO before authorization of payment is given for a surgery.

(8) Hospital admissions do not require PA unless the procedure requires PA.

(9) PA is not required for emergent or urgent procedures or services.

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

(11) Refer to Table 130-0200-1 for all services/procedures requiring prior authorization.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

Table 130-0200-1 Prior Authorization

00580	21151	21267	22808
00796	21154	21268	22810
00938	21155	21270	22812
11960	21159	21275	22841-22848
11970	21160	21280	22851
15822	21172	22554	23472
15823	21175	22556	26560-26562
17106-17108 [1]	21179-21184	22558	27447
19350	21188	22585	28340
19367-19369	21193-21196	22590	28341
20910	21198	22595	28344
21050	21199	22600	28345
21137-21139	21206	22610	30400
21141-21143	21208	22612	30410
21145-21147	21209	22614	30420
21150	21256	22630	30430
	21260	22632	30435
	21261	22800	30450
	21263	22802	30460
		22804	

[1] Authorized for facial lesions only, if meets other PA requirements

30462

32851-32854[2]

33935[2]

33945[2]

38204-38215[2]

38230[2]

38240[2]

38241[2]

40840

40842-40845

43631-43634

47135[2]

47136[2]

47140-47142[2]

48160[2]

48554[2]

48556[2]

49000[3]

49320

49329

51840

51841

51845

54360

54400

54401

54405

54408

54410

54411

54416

54417

56805

57284

57288

57291

57292

57335

58150

58152

58180

58260

58262-58263

58267

58270

58275

58280

58285

58290-58294

58400

58410

58550

58552-58554

58660

58661

58672

58673

58720

58940

62351

63001

63003

63005

63011-63012

63015-63017

63020

63030

63035

[2] Medical Director's Office

[3] If an elective procedure

63040

63042-63048

63055-63057

63064

63066

63075-63078

63081

63082

63085-63088

63090

63091

63101-63103

63170

63172-63173

63180

63182

63185

63190

63191

63194-63200

63250-63252

63265-63268

63270-63273

63275-63278

63280-63283

63285-63287

63290

63300-63308

65125

65130

65135

65140

65150

65155

67311[4]

67312[4]

67314[4]

67316[4]

67318[4]

67320[4]

67331[4]

67332[4]

67334[4]

67335[4]

67340[4]

67550

67560

[4] PA not required for under age 21

67900-67904

67906

67908

67909

67911

67912

67914-67917

78459

78491

78492

78608

78609

78810

92507

G0125

G0210-G0234

4-1-04

410-130-0220 Not Covered/Bundled Services

(1) Refer to the Oregon Health Plan Administrative Rules (OAR 410-141-0520) and General Rules (Chapter 410, Division 120) for coverage of services. Refer to Table 130-0220-1 for additional information regarding not covered services or for services that are considered by OMAP to be bundled. The following are examples of not covered services:

(a) "After hours" visits during regularly scheduled hours;

(b) Psychotherapy services (covered only through local Mental Health Clinics and Mental Health Organizations);

(c) Room charges (only services and supplies covered);

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

(e) Services provided at the client’s request in a location other than the practitioner's office that are normally provided in the office;

(f) Telephone calls for purposes other than tobacco cessation and maternity case management.

(2) This is not an inclusive list. Specific information is included in the Office of Medical Assistance Programs (OMAP) General Rules, Medical Assistance Benefits: Excluded Services and Limitations (OAR 410-120-1200).

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

Table 130-0220-1 Not Covered/Bundled Services

Refer to the HSC List for additional not covered services.

BND = bundled services that are included in the base service.

00802

19316

32850 BND

33930 BND

33940 BND

47133-47134 BND

48550 BND

58740 BND

74740

74742

78990 [1]

79900 [1]

80414-80415

82757

84030

84830

86910-86911

88000-88099

89250-89261

89264

89268

89272

89280-89281

89290-89291

89300

89310

89320-89321

89325

89329-89330

89335

89342-89344

89346

89352-89354

89356

90473-90474

90660

92508

92559

92592

92593 [2]

92595 [2]

99000-99002 BND

99070 [1]

99100 BND

99116 BND

99135 BND

99140 BND

99360 [3]

A4641-A4643 BND

A4647 BND

A4570 [4]

A4580 [4]

A4590 [4]

---

[1] Use HCPCS

[2] Not covered for ages 21 and older

[3] Covered only for standby at caesarean/high-risk delivery of newborn

[4] Use Q4001-Q4051

B4034-B4036

B4100-B9999

E Codes [5]

G0030-G0047

G0252-G0254

J3520

J3570

K0000-K9999

L1844

L2750

L2780

L3251

L5610

L5613-L5614

L5722

L5724

L5726

L5728

L5780-L5822

L5824

L5828

L5830

L5847-L5848

L5980

L5989

L6025

L6310

L6360

L6638

L6646

L6648

L6825

L6875

L6881-L6882

L6920

L6925

L6930

L6935

L6940

L6945

L6950

L6955

L6960

L6965

L6970

L6975

L7010

L7015

L7020

L7025

L7030

L7035

L7040

L7045

L7170

L7180

L7185-L7186

L7190-L7191

L7260-L7261

L7266

L7272

L7274

L7360

L7362

L7364

L7366-L7368

L7500

L7520

L7900

[5] Refer to DME Table 130-0700-1

L8001-
L8002

L8010

L8035

L8039

L8500-
L8501

L8505

L8507

L8510-
L8514

L8600

L8603

L8606

L8610

L8612-
L8614

L8619

L8630-
L8631

L8641-
L8642

L8658-
L8659

L8670

L8699
L9900

M0075

M0076

M0100

M0300-
M0301

P2028-
P2029

P2031

P2033

P2038

P7001

P9010-
P9012

P9016-
P9023

P9031-
P9048

P9050-
P9060

Q0091 BND

Q0092 BND

Q0114-
Q0115

4-1-04

410-130-0225 Teaching Physicians

(1) Supervising faculty physicians in a teaching hospital may not bill the Office of Medical Assistance Programs (OMAP) on a HCFA-1500 when serving as an employee of the hospital during the time the service is provided or when the hospital reports the service as a direct medical education cost on the Medicare and OMAP cost report.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
October 1, 2003

410-130-0230 Administrative Medical Examinations and Reports

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

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

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

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
October 1,2003

410-130-0240 Medical Services

(1) All medical and surgical services requiring prior authorization (PA) are listed in OAR 410-130-0200 PA Table 130-0200-1 and services that are Not Covered/Bundled services are listed in OAR 410-130-0220 Table 130-0220-1. Table 130-0220-1 only contains clarification regarding some services that are not covered. Refer to the Health Services List of Prioritized Services for additional information regarding not covered services.

(2) Acupuncture may be performed by a physician, a physician's employee-acupuncturist under the physician's supervision, or a licensed acupuncturist, and bill using CPT 97780 or 97781.

(3) Anesthesia is not covered for procedures that are below the funding line on the Health Services Commission's Prioritized List of Health Services:

(a) Reimbursement is based on the base units listed in the current American Society of Anesthesiology Relative Value Guide plus one unit per each 15 minutes of anesthesia time. Exceptions–anesthesia for neuraxial labor analgesia/anesthesia must be billed at the base units plus one unit for each 15 minutes of face-to-face contact time;

(b) Bill total quantity on one line of the base units plus one unit for each 15 minutes of anesthesia time. For the last fraction of time under 15 minutes, bill one unit for 8-14 minutes. Do not bill a unit for 1-7 minutes of time;

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

(d) A valid consent form is required for all hysterectomies and sterilizations;

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

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

(4) Chiropractic services must be billed using 99202 and 99212 for the diagnostic visits and 98940-98942 for manipulation. Use CPT lab and radiology codes, which most accurately identifies the services performed.

(5) For Maternity Care and Delivery use Evaluation and Management codes when providing three or fewer antepartum visits:

(a) For births performed in a clinic or home setting, use CPT codes that most accurately describe the services provided. HCPCS supply code S8415 may be billed in addition to the CPT procedure code. Code S8415 includes all supplies, equipment, staff assistance, birthing suite, newborn screening cards, topical and local anesthetics. Bill medications (except topical and local anesthetics) with HCPCS codes that most accurately describe the medications;

(b) For labor management only, bill 59899 and attach a report;

(c) For multiple births, bill the highest level birth with the appropriate CPT code and the other births under the delivery only code. For example, for total OB with cesarean delivery of twins, bill 59510 for the first delivery and 59514 for the second delivery.

(6) Mental Health and Psychiatric Services:

(a) Administrative Exams and reports for Psychiatric or psychological evaluations refer to the Administrative Exam rules;

(b) Psychiatrists can be reimbursed by OMAP for symptomatic diagnosis and services which are somatic (physical) in nature. Contact the local Mental Health Department for covered psychiatric and psychological services;

(c) Mental Health Services – Must be provided by local Mental Health Clinics or a client's Mental Health Organization (MHO). Not payable to private physicians, psychologists, and social workers.

(7) Neonatal Intensive Care Unit (NICU) procedure codes 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:

(a) Consultations by specialists other than neonatologists and pediatric intensivists are payable in addition to these codes;

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

(8) Neurology/Neuromuscular–Payment for polysomnographs and multiple sleep latency test (MSLT) are each limited to two in a 12-month period.

(9) Ophthalmology Services–Routine eye exams for the purpose of glasses or contacts are limited to one examination every 24 months for adults. All materials and supplies must be obtained from OMAP's contractor. Refer to the Vision Program Rules for more information.

(10) Special Services and Reports–OMAP will pay for procedure codes 99052 or 99054 only when the service provided is outside the practitioner's usual or scheduled working hours. These services are not payable to emergency room based physicians.

(11) Speech & Hearing–HCPCS codes V5000-V5299 are limited to speech-language pathologists, audiologists, and hearing aid dealers:

(a) Refer to the Speech and Hearing Program Rules for detailed information;

(b) Payment for hearing aids and speech therapy must be authorized before the service is delivered;

(c) CPT 92593 and 92595 Covered for children under age 21.

Statutory Authority: ORS Chapter 409

Statutes Implemented: 414.065

4-1-04

410-130-0245 EPSDT Program

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

(2) Screening Exams:

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

(b) Periodic EPSDT screening exams must include:

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

(B) Assessment of nutritional status;

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

(D) Appropriate immunizations;

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

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

(G) Health education including anticipatory guidance;

(H) Appropriate hearing and vision screening.

(c) The provider may bill for both lab and non-lab services using the appropriate CPT and HCPCS codes. Immunizations must be billed according to the guidelines listed in OAR 410-130-0255;

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

(3) Referrals:

(a) If, during the screening process (periodic or inter-periodic), a medical, mental health, substance abuse, or dental condition is discovered, the client may be referred to medical providers, Mental Health and Developmental Disabilities Services Division, Office of Alcohol and Drug Abuse Programs, or dental providers for further diagnosis and/or treatment;

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

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

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

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

(5) Lead Screening/Testing Questionnaire: Complete the Lead Screening/Testing Questionnaire (OMAP 9033) found in the

"Appendix" section of the Medical-Surgical Services provider rule. The questionnaire must be used at each EPSDT exam beginning at one year of age to assess the potential for lead exposure. Retain this questionnaire in the client's medical record. Do not attach this form to the claim for reimbursement. OMAP does not stock this form; photocopy the form and the instructions from the Medical-Surgical Services rule.

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

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

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

(9) Target Zip Codes -- The following applies to Multnomah County only:

(a) All children (as defined in the "Blood Lead Screening" section of this rule) who live in certain Multnomah County zip codes must have a screening blood lead test performed, and follow-up as described in this rule;

(b) Those zip codes are: 97201 through 97206, 97209 through 97220, 97227, 97231, 97232 and 97266;

(c) While the Lead Screening/Testing Questionnaire (OMAP 9033) is not mandatory for these children, the blood lead sample must be accompanied by all identifying and demographic information on the questionnaire.

Table 130-0245-1, Table 130-0245-2, Table 130-0245-3, Table 130-0245-4, Table 130-0245-5.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
October 1, 2003

Table 130-0245-1 Schedule For Diagnostic Testing

The following is the schedule for diagnostic testing of a child with an elevated BLL on a screening test.

Screening test (µd/dL) result is:	Perform diagnostic test on venous blood within
10-19	3 months
20-44	1 month - 1 week*
45-59	48 hours
60-69	24 hours
≥70	Immediately as an emergency lab test

* The higher the screening BLL, the more urgent the need for a diagnostic test.

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

Diagnostic test – the first venous (venipuncture) blood lead test performed within 6 months on a child who has previously had an elevated Blood Lead Level on a screening test.

Table 130-0245-2 Comprehensive Follow-up Services

Diagnostic BLL (µg/dL)	Action
<10	Reassess or re-screen in one year. No additional action necessary unless exposure sources change.
10-14	Provide family lead education. See Table 130-0245-4. Provide follow-up testing.* Refer for social services, if necessary.
15-19	Provide family lead education. See Table 130-0245-4. Provide follow-up testing.* Refer for social services, if necessary. If BLLs persist (i.e., 2 venous BLLs in this range at least 3 months apart) or worsen, proceed according to actions for BLLs 20-44.
20-44	Provide coordination of care (case management). Provide clinical management. See Table 130-0245-5. Provide environment investigation. Provide lead-hazard control. Call 1-800-422-6012 at OHD to receive a lead hazard control booklet, and your Local Health Department for other information.
45-69	Within 48 hours, begin coordination of care (case management), clinical management (see Table 130-0245-5), environmental investigation, and lead hazard control.
≥70	Hospitalize child and begin medical treatment immediately. Begin coordination of care (case management), clinical management (see Table 130-0245-5), environmental investigation, and lead-hazard control immediately.

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

October 1, 2003

Table 130-0245-3 Anticipatory Guidance

Anticipatory guidance should be provided prenatally, and at every well-child visit, beginning at one year of age. Parental guidance at these times might prevent some lead exposure and the resulting increase in BLLs that often occurs during a child's second year of life.

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

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

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

Call 1-800-422-6012 (OHD) for a lead hazard control booklet, and your local Health Department for other information.

Table 130-0245-4 Family Lead Education

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

Their child's BLL, and what it means.

Potential adverse health effects of the elevated BLL.

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

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

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

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

Results of environmental inspection, if applicable. (Check with local Health Department)

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

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

Table 130-0245-5 Clinical Management

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

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

Provide clinical management for children when appropriate. Clinical management includes: Clinical evaluation for complications of lead poisoning. Family lead education and referrals Chelation therapy, if appropriate Follow-up testing at appropriate intervals.

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

410-130-0255 Immunizations and Immune Globulins

(1) Use standard billing procedures for vaccines that are not part of the Vaccines for Children (VFC) Program.

(2) Synagis (palivizumab-rsv-igm) is covered only for high-risk infants and children as defined by the American Academy of Pediatric guidelines. Use 90378 for Synagis.

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

(4) Vaccines for Children (VFC) Program:

(a) Under this federal program, certain immunizations are free for clients ages 0 through 18. OMAP does not reimburse the cost of vaccine serums covered by this federal program;

(b) Use the following procedures when billing immunizations included in the VFC Program:

(A) When the sole purpose of the visit is to administer a VFC immunization(s), the provider should bill the appropriate immunization procedure code(s) with modifier -26, or -SL for each injection. Do not bill CPT code 90471-90474 or 99211;

(B) When the immunization is administered as part of an Evaluation and Management service (e.g., well-child visit) the provider should bill the appropriate immunization code with modifier -26, or -SL for each injection in addition to the Evaluation and Management code.

(c) Refer to Table 130-0255-1 for immunization codes included in the VFC Program for clients ages 0 through 18.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.06

4-1-04

Table 130-0255-1 Vaccines For Children

90632[1]	90713
90633	90716
90636[1]	90718
90645	90721[3]
90647-90648	90723
90655[2]	90732[4]
90657[2]	90740
90658[3]	90744
90669	90746[1]
90700	90747
90702	90748
90707	

[1] Age 18 only.

[2] All healthy children ages 6-23 months and all at-risk children as defined by the Health Services Immunization Program ages 24 months through 35 months.

[3] All at-risk children as defined by the Health Services Immunization Program ages 3 through 18 years.

[3] Use when 90700 and 90648 are given combined in one injection.

[4] Only for high risk clients as defined by the Health Services Immunization Program ages 2-18 years.

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

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

(2) If the client has Medicare and Medicare does not allow the specific surgery in an ASC or BC then the surgery may not be performed in an ASC or BC.

(3) Global Rates include:

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

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

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

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

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

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

(g) Blood, blood plasma, platelets;

(h) Materials for anesthesia;

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

(4) Items and Services Not Included in ASC or BC Global Rate:

(a) Practitioner services such as those performed by physicians, licensed physician assistants, nurse practitioners, certified nurse anesthetists, dentists, and podiatrists;

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

(c) Prosthetic devices;

(d) Ambulance services;

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

(f) Artificial legs, arms, and eyes;

(g) Services furnished by a certified independent laboratory.

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

(6) Procedure Coding:

(a) For reduced or discontinued procedures, use CPT instructions and add appropriate modifiers;

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

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
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410-130-0380 Surgery Guidelines

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

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

(3) Global payment for major surgery includes:

(a) Surgery;

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

(c) Initial admission history and physical;

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

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

(f) Hospital discharge.

(4) Global payment for minor surgery includes:

(a) Surgery;

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

(c) Initial admission history and physical;

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

(e) Hospital discharge.

(5) Global payment for endoscopy includes:

(a) Surgery;

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

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

(d) Pre-operative and post-operative care provided by the surgeon's associate(s) or by another physician "on call" for the surgeon are considered included in the reimbursement to the surgeon and will not be paid in addition to the payment to the surgeon;

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

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

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

(b) Payment will be determined by medical review.

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

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

(b) Payment will be determined by medical review.

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

(a) Primary Procedure paid at 100% of OMAP's maximum fee for that procedure;

(b) Second and third procedure paid at 50% of OMAP's maximum fee;

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

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

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

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

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

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

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

(a) The assistance must be medically appropriate;

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

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

(d) Use an appropriate modifier to indicate assistance.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: PWC 868, f. 12-30-77, ef. 2-1-78; AFS 32-1978, f. & ef. 8-1-78; AFS 26-1980, f. 5-21-80, ef. 6-1-80; AFS 27-1982, f. 4-22-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 2-1983, f. 1-31-83; AFS 57-1983, f. 11-29-83, ef. 1-1-84; AFS 4-1984, f. & ef. 2-1-84; AFS 30-1984, f. 7-26-84, ef. 8-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-984; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 30-1987, f. 7-15-87, ef. 8-1-87; AFS 56-1987, f. 10-29-87, ef. 11-1-87; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; Renumbered from 461-014-0048, 461-014-0049, 461-014-0053, 461-014-0055 & 461-014-0056; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-014-0710; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 23-1992, f. 7-31-92, cert. ef. 8-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01,

410-130-0562 Abortion

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

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

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

(4) .For services related to surgical abortion such as lab, ultrasound and pathology bill separately. Add modifier U4 (an OMAP modifier) for surgical abortion related services.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

October 1, 2003

410-130-0580 Hysterectomies and Sterilization

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

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

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

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

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

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

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

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

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

(5) In cases of retroactive eligibility:

(a) The physician who performs the hysterectomy must certify in writing one of the following:

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

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

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

(b) Additional supplies of the Hysterectomy Consent form (OMAP 741) may be obtained through the DHS Distribution Center.

(6) Do not use the Consent to Sterilization form (OMAP 742) for hysterectomies.

(7) Mail a copy of the Hysterectomy consent form to OMAP-HFO, Claims Management.

(8) Do not submit a copy of the Hysterectomy consent form with the claim.

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

(10) Voluntary Sterilization:

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

(A) In labor;

(B) Seeking or obtaining an abortion; or

(C) Under the influence of alcohol or drugs.

(b) Age 15 and over:

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

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

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

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

(C) The person must be legally competent to give informed consent. The physician performing the procedure, and the person obtaining the consent if other than the physician, must review with the person the detailed information appearing on the Consent to Sterilization form regarding effects and permanence of the procedure, alternative birth control methods, and explain that withdrawal of consent at any

time prior to the surgery will not result in any loss of other program benefits.

(c) Under age 15 -- The parent or guardian must sign the consent form more than 30 days before the date of the procedure.

(11) Involuntary Sterilization -- Minors (15 years to 21 years) and incapacitated clients:

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

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

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

(12) Submitting the Consent to Sterilization Form:

(a) After the sterilization is performed, a copy of the completed Consent to Sterilization form (OMAP 742) should be mailed by the performing surgeon to OMAP-HFO, Claims Management, in Salem;

(b) OMAP will review the form for errors and either call the provider or mail the form back if there are discrepancies. The Consent to Sterilization form must be completed in full. Consent forms submitted to OMAP without the client's signature or the date of signature by the client are invalid; clients may not sign or date the consent form retroactively;

(c) Do not submit the OMAP 742 with the claim;

(d) Initial claims by the surgeon, anesthesiologist and hospital will be paid without review for the consent form. All sterilization claims will be reviewed during a post-payment audit. If the OMAP 742 is missing or invalid, payments directly related to the sterilization will be recouped from the surgeon, anesthesiologist and hospital.

(13) How to Complete the Consent to Sterilization Form:

(a) Enter the client's name, sex, and recipient number where indicated;

(b) Client's Statement:

(A) 1 -- Enter the name of the doctor or clinic;

(B) 2 -- Enter the name of the surgical procedure;

(C) 3 -- Check the appropriate age box and enter the birth date;

(D) 4 -- Enter the client's name, the name of the doctor performing the procedure, and the name of the operation to be performed;

(E) 5 -- Optional;

(F) 6 -- The client must sign and date the consent.

(c) Interpreter's Statement – Complete only if an interpreter is required:

(A) 7 -- Enter the name of the language used to explain the consent to the client;

(B) 8 -- The interpreter must sign and date the consent on the same date as the client.

(d) Statement of Person Obtaining Consent:

(A) 9 -- Enter the client's name and the name of the procedure to be performed;

(B) 10 -- Check appropriate age box;

(C) 11 -- The person obtaining the consent must sign, date, and enter the name and full address of the physician or facility. The date of

signature must be on or after the date the client signs the consent, but before the procedure is performed.

(e) Physician's Statement:

(A) 12 -- Enter the client's name, the date the procedure was performed, and the name of the procedure to be performed;

(B) 13 -- Check the appropriate age box;

(C) 14 -- Check the appropriate box. If the second box is checked, check the appropriate circumstance and provide further information;

(D) 15 -- The performing physician must sign this consent. The date of signature must be either the date the sterilization was performed or a date following the sterilization.

(f) Mail a copy of the Consent to Sterilization form to: OMAP -- POS, Claims Resolution.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
October 1, 2003

410-130-0585 Family Planning Services

(1) Family planning services are available to individuals of childbearing age (including minors who can be considered to be sexually active) who desire such services. Family planning services are those intended to prevent or delay pregnancy, or otherwise control family size. Counseling services, laboratory tests, medical procedures, and pharmaceutical supplies and devices are covered if provided for family planning purposes. Bill these services using appropriate CPT and HCPCS codes and add modifier FP.

(2) Clients may seek family planning services from any provider enrolled with OMAP, even when the client is enrolled in a Managed Care Organization (MCO):

(a) If the provider is a participating provider with the client's MCO, the MCO must be billed;

(b) If the provider is not a participating provider with the client's MCO, bill OMAP directly and mark the family planning box (24H) on the CMS-1500 claim form.

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

(4) Bill all family planning with the most appropriate ICD-9-CM diagnosis codes in the V25 series (Contraceptive Management) and add modifier FP to all procedure codes.

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

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

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

410-130-0587 Family Planning Clinic Services

(1) This rule is to be used only by family planning clinics.

(2) Family planning clinics are governmental agencies that receive Title X funding from the state for family planning (FP) services and non-governmental providers who have contractual agreements approved by the Office of Family Health to provide family planning services.

(3) Family planning clinics will be reimbursed an encounter rate only for all FP services where the primary purpose of the visit is for family planning.

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

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

(A) Annual family planning exams;

(B) Family planning counseling;

(C) Insertions and removals of implants and IUDs;

(D) Diaphragm fittings;

(E) Dispensing of contraceptive supplies and medications;

(F) Contraceptive injections.

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

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

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

(5) Reimbursement for T1015 does not include payment for FP supplies and medications.

(a) Bill FP supplies and medications separately using HCPCS codes. Where there are no specific HCPCS code~~s~~, use an appropriate unspecified HCPCS code and bill at acquisition cost:

(A) Bill spermicide code A4269 per tube;

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

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

(b) Add modifier FP after all codes billed for contraceptive services, supplies and medications.

(6) Reimbursement for T1015 does not include laboratory tests.

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

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

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

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

(8) When billing for services provided to clients enrolled in a Managed Care Organization, mark the family planning Box 24 H on the CMS-1500 billing form.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
4-1-04

410-130-0595 Maternity Case Management (MCM)

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

(2) This program:

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

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

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

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

(e) Allows for billing for intensive nutritional counseling services.

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

(4) NOTE: In situations where multiple providers are seeing one client for MCM services, the case manager must coordinate care to ensure claims are not submitted to the Office of Medical Assistance Programs (OMAP) if services are duplicated.

(5) Definitions:

(a) Case Management -- An ongoing process to assist the individual client in obtaining access to and effective utilization of necessary

health, social, economic, nutritional, and other services as defined in the Client Service Plan (CSP) or other documentation;

(b) Case Management Visit -- A face-to-face encounter between a maternity case manager and the client that must include two or more specific training and education topics, addresses the CSP and provides on-going relationship development between the client and the case manager;

(c) Client Service Plan (CSP) -- A written systematic, client coordinated plan of care which lists goals and actions required to meet the needs of the client as identified in the Initial Assessment and includes a client discharge plan/summary;

(d) High Risk Case Management -- Intensive case management services provided to a client identified and documented by the maternity case manager or prenatal care provider as being high risk;

(e) High Risk Client -- Includes clients who have current (within the last year) documented alcohol, tobacco or other drug (ATOD) abuse history, or who are 17 or under, or have other conditions identified in the initial assessment instrument;

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

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

(A) Initial assessment;

(B) Client interviews;

(C) Available records;

(D) Contacts with collateral providers;

(E) Other professionals; and

(F) Other parties on behalf of the client.

(h) Nutritional Counseling -- Intensive nutritional counseling for clients who have at least one of the following documented conditions:

(A) Chronic disease, e.g., diabetes, renal disease;

(B) Hematocrit (Hct) less than 34, (Hemoglobin (Hgb) 11) first trimester, Hct 32 (Hgb10) second or third trimester;

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

(D) Pregnancy weight gain outside the appropriate WIC guidelines;

(E) Eating disorder;

(F) Gestational diabetes;

(G) Hyperemesis;

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

(I) Other conditions identified by the maternity case manager, physician or prenatal care provider for which adequate services are not accessible through another program.

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

(j) Telephone Case Management Visit -- A non-face-to-face encounter between a maternity case manager and the client providing identical services of a Case Management Visit (G9012).

(6) Maternity Case Manager Qualifications:

(a) Maternity case managers must be:

(A) Currently licensed as a:

(i) Physician;

(ii) Physician Assistant;

(iii) Nurse Practitioner;

(iv) Certified Nurse Midwife;

(v) Direct Entry Midwife;

(vi) Social Worker; or

(vii) Registered Nurse;

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

(B) Other paraprofessionals may provide specific services while working under the supervision of one of the practitioners listed in

(6)(a)(A) of this rule.

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

(7) Nutritional Counselor Qualifications -- Nutritional counselors must:

(a) Be a registered dietician; or

(b) Have a bachelor's degree in a nutrition-related field with two years of related work experience.

(8) Documentation Requirements:

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

(b) A correctly completed OMAP form 2470, 2471, and 2472, or their equivalents meet minimum documentation requirements for Maternity Case Management Services.

(9) G9001 -- Initial Assessment, includes:

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

(b) Development of a CSP which addresses needs identified;

(c) Making referrals as needed;

(d) Assisting with a referral to a prenatal care provider as needed;

(e) Forwarding of the initial assessment and other relevant information to the on-going maternity case manager and prenatal care provider;

(f) Communicating pertinent information to others participating in the client's medical and social care.

(g) The client's record must reflect the date and to whom the initial assessment was sent;

(h) Paid one time per pregnancy per provider. No other MCM service can be performed until after an initial assessment has been completed. No other maternity management codes except a Home/Environmental Assessment (G9006) and a Case Management Visit (G9012) may be billed the same day as an initial assessment.

(10) G9002 -- Case Management (Full Service) -- Includes:

(a) Face-to-face client contacts;

(b) Implementation and monitoring of a CSP:

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

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

(c) Referral to services included in the CSP:

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

(B) Maintain contact with resources to ensure service delivery, share information, and assist with coordination.

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

(e) Training, information, and education. Refer to Table 130-0595-1;

(f) Linkage to labor and delivery services;

(g) Linkage to family planning services as needed;

(h) CSP coordination as follows:

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

(B) Contact with prenatal care provider;

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

(i) Client advocacy as necessary to facilitate access. The case manager serves as a client advocate and intervenes with agencies or persons to help the client receive appropriate benefits or services;

(j) Assist client in achieving the goals in the CSP. The case manager will advocate for the client when resources are inadequate or the service delivery system is non-responsive;

(k) Paid one time per pregnancy. Bill after delivery when more than three months of service were provided. Services must be initiated prenatally and carried through the date of delivery.

(11) G9009 -- Case Management (Partial Service):

(a) Can be billed when the CSP has been developed and case management services (G9002) were initiated prenatally and partially completed;

(b) Served client three months or less.

(12) G9005 -- High Risk Case Management (Full Service):

(a) Requires at least eight case management visits;

(b) Paid one time per pregnancy after delivery when more than three months of services were provided to the client;

(c) Served client more than three months;

(d) Can be billed in addition to G9002.

(13) G9010 -- High Risk Case Management (Partial Service):

(a) Payable when the client becomes "high risk" during the latter part of the pregnancy or intensive high risk MCM services were initiated and partially completed but not carried through to the date of delivery;

(b) Served client three months or less;

(c) Can be billed in addition to G9002 or G9009.

(14) S9470 -- Nutritional Counseling:

(a) Available for clients who have at least one of the documented conditions listed in the "Definitions" section of this rule;

(b) Documentation must include all of the following:

(A) Nutritional assessment;

(B) Nutritional care plan;

(C) Regular client follow-up.

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

(d) Paid one time per pregnancy.

(15) G9006 -- Home/Environment Assessment:

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

(b) One Home/Environment Assessment may be billed per pregnancy. Additional Home/Environment Assessments may be billed with documentation of problems and necessary follow-up or when client moves. Documentation must be submitted with the claim to support the additional home/environment assessment.

(16) G9011 -- Telephone Case Management Visit:

(a) A non-face-to-face encounter between a maternity case manager and the client, meeting all requirements of a Case Management Visit (G9012) and when a face-to-face Case Management Visit is not possible or practical;

(b) In lieu of a Case Management visit and counted towards the total number of Case Management Visits (see G9012 for limitations).

(17) G9012 -- Case Management Visit:

(a) Each Case Management Visit must include an evaluation and/or revision of objectives and activities addressed in the CSP and training, information and education regarding at least two topics in Table 130-0585-1;

(b) Four Case Management Visits may be billed per pregnancy. Telephone contacts (G9011) are included in this limitation;

(c) Six additional Case Management Visits may be billed if the client is identified as High Risk. These additional visits may not be billed until after delivery. Bills for these additional six visits may only be submitted with or after High-Risk Full (G9005) or Partial (G9010) case management has been billed. Telephone contacts (G9011) are included in this limitation;

(d) May be provided in the client's home or other site.

Table 410-147-0595-1

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
October 1, 2003

Table 130-0595-1 MCM Education, Training and Prevention Topics

Client Service Plan

Training & Education

Maternal/Fetal HIV Transmission
Fetal Alcohol Syndrome
Prevention Early Childhood Caries
Maternal Oral Health
Prevention for Tobacco Use
Lead Exposure and Screening
Immunizations

Environmental Assessment

General Assessment

General Condition of House
Adequacy of Shelter
Food Storage Facilities & Food Preparation Facilities
Health Adequacy: Safety and sanitation
Heating/Cooling/Ventilation
Number of Bedrooms vs. Number of People
Running water
Phone service
Sanitation/Sewer
Environmental Hazards
Toxins/Teratogens

Safety

Guns: Locked and Unloaded
Smoke Alarm: Installed & Working
Fire Prevention: i.e. smoking habits, if applicable
Adequate Exits: All locations & free of obstacles

Toxins

Lead Exposure: Peeling paint, lead pipes & lead dust
Chemical Use: In or near home
Asbestos

Pet

Cats (Toxoplasmosis)
Birds (Psittacosis)
Reptiles (Salmonella), i.e., iguanas, turtles, snakes

Table 130-0595-1 MCM Education, Training and Prevention Topics

Case Management Visits

Pre-term Birth Prevention

Factors associated with increased risk
Early detection of symptoms
Obtaining help/information
Stress reduction
Oral Health Status

Pregnancy & Childbirth

Common discomforts
Pregnancy danger signs & symptoms
Labor and birth process
Coping strategies
Common interventions
Emergencies

Health Status

Rest/exercise
Digestive tract changes
Weight gain
Food availability
Food selection/preparation
Nutrition
Nutrient/calorie intake
Medications
Maternal Oral Health

Environment

Health Adequacy
Safety and Sanitation
Environmental Hazards
Toxins/Teratogens
Fluoridated Water Area

Emotional

Stress reduction

Coping strategies
Hormonal changes
Relationships

Other

Family planning
Sexually Transmitted Diseases
Substance/alcohol use

Infant Care/Parenting

Feeding/nutrition/infant growth
Clothing needs
Infant sleep patterns and location
Wellness care/immunizations
Prevention of Early Childhood Cavities
Breastfeeding
SIDS and Back To Sleep
Developmental milestones
Common interventions
Emergencies
Safety
Infant/parent interaction
Bonding/attachment
Infant communication patterns/cues
Parental frustration/sleep deprivation
Household management support
Community resources
Child nurturing/protection

410-130-0670 Death With Dignity

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

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

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

(a) The medical confirmation of the terminal condition;

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

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

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

(e) Counseling consultation(s); and

(f) Medication and dispensing.

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

(5) Billing:

(a) All claims for Death With Dignity services shall be made on a HCFA-1500 billing form;

(b) Claims shall be submitted using appropriate CPT encounter and procedure codes;

(c) OMAP unique diagnosis code PAD-00 must be used in Field 21 of the HCFA-1500 billing form. No additional codes may be listed in Field 21 for a claim for reimbursement for Death With Dignity services;

(d) Claims shall be submitted to: OMAP, PO Box 992, Salem, Oregon 97308-0992;

(e) Prescriptions shall be billed using the OMAP unique code 8888-PAID-00 only. This code must be placed in Field 24D of the HCFA-1500. In addition, list the actual NDC number for the drug dispensed in Field 19, "reserved for local use," of the HCFA-1500;

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 46-1998, f. & cert. ef.12-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 2-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00

410-130-0680 Laboratory and Radiology

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

(2) Payment for newborn screening kits and collection and handling for newborn screening (NBS) tests performed by the Oregon State Public Health Laboratory (OSPHL) is considered bundled into the delivery fee. Replacement of lost NBS kits may be billed with code S3620 with modifier TC if the loss is documented in the client's medical record. Newborn screening confirmation tests performed by reference laboratories at the request of the OSPHL shall be reimbursed only to the OSPHL.

(3) Transplant lab codes are covered only if the transplant is covered and if the transplant service has been authorized.

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

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

(6) The claim must indicate the date of the specimen collection as the date of service (DOS) regardless of the actual date the test was performed.

(7) A provider who sends a specimen to another provider for testing may bill the Office of Medical Assistance Programs (OMAP) only for drawing a blood sample venipuncture or capillary puncture or collecting a urine sample by catheterization:

(a) Venipuncture or capillary puncture and urinary catheterization are payable only once per day regardless of the frequency performed;

(b) Collection and/or handling of other specimens (such as PAP or other smears, voided urine samples, or stool specimens) are

considered bundled into the exam and/or lab procedures and are not payable in addition to the laboratory test.

(8) Pass-along charges from the performing laboratory to another laboratory, medical practitioner, or specialized clinics do not qualify for payment and are not to be billed to OMAP.

(9) Charges for tests performed by independent clinical laboratories may only be billed by and paid to the performing provider or a designated billing agent.

(10) Laboratory Certification--Laboratory services are reimbursable only to facilities with a current, valid Oregon State clinical laboratory license issued by the Oregon Health Division or to laboratories outside of Oregon which are certified by the Centers for Medicare and Medicaid Services (CMS) and meets the requirements of the Clinical Laboratory Improvement Amendments (CLIA) and the provider has notified OMAP of the assigned ten-digit CLIA number. Payment is limited to the level of testing authorized by the state license or CLIA certificate at the time of test performance.

(11) Organ Panels:

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

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

(12) CLIA requires all entities that perform even one test, including waived tests on... "materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings" to meet certain Federal requirements. If an

entity performs tests for these purposes, it is considered under CLIA to be a laboratory.

(13) Radiology:

(a) Provision of diagnostic and therapeutic radionuclide(s), HCPCS A9500-A9699, is payable only when used in conjunction with diagnostic nuclear medicine procedures (CPT codes 78000 through 78999) or radiation therapy and radiopharmaceutical procedures (CPT codes 77401-77799 and 79000-7999);

(b) Bill routine screening mammography under CPT code 76092;

(c) HCPCS codes R0070 through R0076 are covered.

(14) Contrast and diagnostic-imaging agents -- Reimbursement is bundled in the radiologic procedure except for low osmolar contrast materials (LOCM). Supply of LOCM (A4644-A4646) may be billed in addition to the radiology procedure only when the following criteria are met:

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

(b) History of asthma or significant allergies;

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

(d) Decrease in renal function;

(e) Diabetes;

(f) Dysproteinemia;

(g) Severe dehydration;

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

(i) Sickle cell disease, or;

(j) Generalized severe debilitation.

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

(a) OMAP pays for only one interpretation of an x-ray or EKG furnished to an emergency room patient, and that is for the interpretation and report that directly contributed to the diagnosis and treatment of the patient;

(b) A second interpretation of an x-ray or EKG is considered to be for quality control purposes only and is not reimbursable;

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

410-130-0700 HCPCS Supplies and DME

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

(2) For items that do not have specific HCPCS codes, use unlisted HCPCS code and bill at acquisition cost, purchase price plus postage.

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

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

(5) Reimbursement for office surgical suites and office equipment is bundled in the surgical procedures.

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

(7) A4000-A8999 HCPCS codes listed in Table 130-0240-1 are covered under this program.

(8) DME/Supply services in the HCPCS series A4000-A9999 which are not listed in Table 130-0240-1 must be referred to a Durable Medical Equipment (DME) provider.

(9) For splints and cast materials, use codes Q4001-Q4051. Do not use A4570, A4580, and A4590.

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

(11) B4000-B9999: HCPCS codes B4034-B4036 and B4150-B9999 are not covered for medical-surgical providers. Refer these services to home enteral/parenteral providers.

(12) E0100-E1799: Only the following DME HCPCS codes are covered for medical-surgical providers when provided in an office setting:

(a) E0100-E0116;

(b) E0602;

(c) E0191;

(d) E1399;

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

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

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

(15) L0000-L9999 Refer to the DME program Administrative rules for coverage criteria for orthotics and prosthetics. Refer to Table 130-0220-1 for a list of “L” codes that are not covered:

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

(A) Measurements;

(B) Moldings;

(C) Orthotic items;

(D) Adjustments;

(E) Fittings;

(F) Casting and impression materials.

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

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

A4220	A4565	E0602
A4260-A4263	A4572	E1399
A4266-A4269	A4644-A4646[1]	[1] *Refer to OAR 410-130-0660*
A4300	A4649	
A4305-A4320	A5051-A5112	
A4322-A4328	A5500-A5507	
A4330-A4331	A5509-A5511	
A4333-A4346	A6010-A6011	
A4348-A4362	A6021-A6224	
A4367	A6231-A6248	
A4369	A6251-A6259	
A4371-A4373	A6261-A6264	
A4375-A4385	A6266-A6406	
A4387-A4399	A6421-A6438	
A4404-A4421	B4081-B4083	
A4460-A4465	B4086	
A4550	E0100-E0116	
A4561-A4562	E0191	