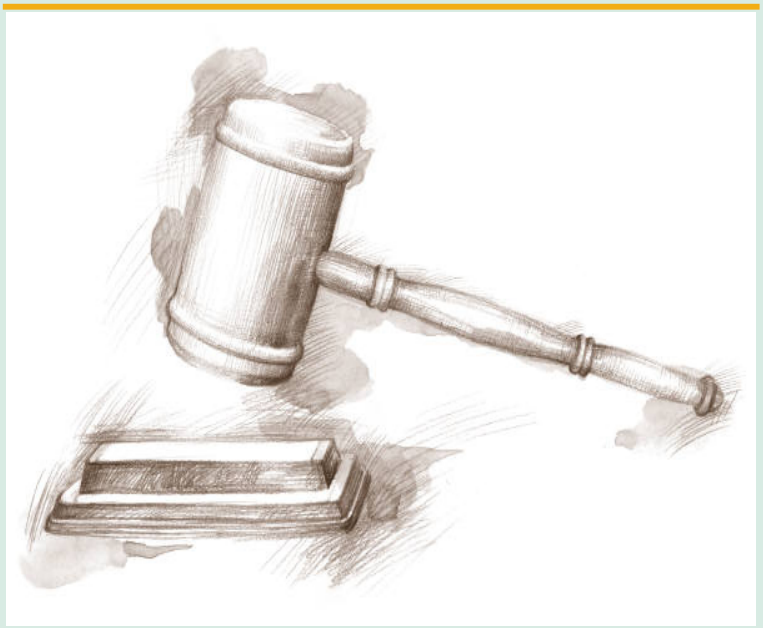
Oregon Health Authority

Medical-Surgical Services Rulebook

Division 130



Includes:

1) Table of Contents
2) Current Update Information (changes since last update)
3) Other Provider Resource Information
4) Complete set of Medical-Surgical Program Administrative Rules

Oregon HEALTH PLAN

OREGON HEALTH AUTHORITY

DIVISION OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 130

MEDICAL- SURGICAL SERVICES

Update Information (most current Rulebook changes)

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Medical-Surgical Services Rulebook

Update Information

for

July 1, 2011

The Division of Medical Assistance Programs (Division) moved from the Department of Human Services (Department) to the Oregon Health Authority (Authority) requiring that all administrative rules be revised to:

- Change “Department” to “Authority” wherever appropriate,
- Update references for statutory authority and statutes implemented, and
- Make other minor corrections where needed

These revisions are typically referred to as non-substantive or “housekeeping” revisions that **do not alter the scope, application or meaning of the rules.**

ORS 183.335 (7): Notwithstanding subsections (1) to (4) of this section, an agency may amend a rule without prior notice or hearing if the amendment is solely for the purpose of:

(a) Changing the name of an agency
(b) Correcting spelling
(c) Correcting grammatical mistakes in a manner that does not alter the scope, application or meaning of the rule
(d) Correcting statutory references

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

Other Provider Resources

DMAP has developed the following additional materials to help you bill accurately and receive timely payment for your services.

Supplemental Information

The Medical-Surgical Services Supplemental Information booklet contains important information not found in the rulebook, including:

- ✓ Prior authorization contacts
- ✓ Imaging prior notification (IPN) instructions and form
- ✓ Primary care management information
- ✓ Billing information, bililng codes, and codebook information
- ✓ Forms, including hysterectomy and sterilization consent forms
- ✓ Pharmaceutical references for prescribing providers
- ✓ Other helpful information not found in the rulebook

Be sure to download a copy of the Medical-Surgical Services Supplemental Information booklet at:

http://www.dhs.state.or.us/policy/healthplan/guides/medsurg/main.html

Note: DMAP revises the supplement booklet throughout the year, without notice. Check the Web page regularly for changes to this document.

Provider Contact Booklet

This booklet lists general information phone numbers, frequent contacts, phone numbers to use to request prior authorization, and mailing addresses.

Download the Provider Contact Booklet at:

http://www.oregon.gov/DHS/healthplan/data_pubs/add_ph_conts.pdf

Other Resources

We have posted other helpful information, including provider announcements, at:
http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml

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http://www.oregon.gov/DHS/govdelivery.shtml

410-130-0000 Foreword

(1) The Division of Medical Assistance Programs (Division) 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 must follow the Division rules in effect on the date of service.

(2) The Division 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 (for specified services only);

(i) Licensed Direct entry midwives;

(j) Portable x-ray providers;

(k) Ambulatory surgical centers;

(l) Chiropractors;

(m) Licensed Dieticians (for specified service only);

(n) Registered Nurse First Assistants;

(o) Certified Nurse Anesthetists;

(p) Clinical Pharmacists.

(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 DMAP 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 on their website at: http://www.oregon.gov/OHPPR/HSC/

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

8-108

2-1-10 (Stat lines only)

7-1-10 (Hk-Stats)

7-1-11 (Hk)

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 Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes;

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

(c) CPT category II (codes with fifth character of “F”) and III codes (codes with fifth character “T”) are not Medical Assistance Program covered services;

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

(3) The Medical-Surgical Service rules list the 2005 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) 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.

(5) 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 the Division of Medical Assistance Programs (Division) or the client. The abbreviation “BND” in the code lists in the DMAP Medical-Surgical Services provider rule indicates the procedure is bundled into another one.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

1-1-07

2-1-10 (Stat lines only)

7-1-10 (Hk-Stats)

7-1-11 (Hk)

410-130-0163 Standard Benefit Package

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

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

07-01-09

7-1-10 (Hk)

7-1-11 (Hk)

410-130-0180 Drugs

(1) The Division of Medical Assistance Programs' (Division) Medical-Surgical Services Program reimburses practitioners for drugs only when administered by the practitioner in the office, clinic or home settings. The Division does not reimburse practitioners for drugs that are self-administered by the client, except for contraceptives such as birth control pills, spermicides and patches:

(a) Use an appropriate Current Procedural Terminology (CPT) therapeutic injection code for administration of injectables;

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

(c) When there is no specific HCPCS code for a drug or biological, use an appropriate unlisted code from the list below and bill at acquisition cost (purchase price plus postage): (A) J3490;

(B) J3590;

(C) J7599;

(D) J7699;

(E) J7799;

(F) J8499;

(G) J8999;

(H) J9999;

(I) Include the name of the drug, National Drug Code (NDC) number and dosage.

(d) Do not bill for local anesthetics; reimbursement is included in the payment for the tray and/or procedure.

(2) The Division requires both the NDC number and HCPCS codes on all claim forms.

(3) For codes requiring prior authorization and codes that are Not Covered/Bundled, refer to OAR 410-130-0200 Table 130-0200-1 and OAR 410-130-0220 Table 130-0220-1.

(4) Not covered services and supplies include:

(a) Laetrile;

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

(c) Dimethyl sulfoxide (DMSO), except for instillation into the urinary bladder for symptomatic relief of interstitial cystitis;

(d) Infertility drugs;

(e) Sodium hyaluronate and Synvisc.(5) 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 Drug Rebate Program -- OAR 410-121-0157.

(A) The Division cannot reimburse providers for a drug unless the drug manufacturer has signed an agreement with the Centers for Medicare and Medicaid Services (CMS) to participate in the Medicaid Drug Rebate Program.

(B) To verify that a drug manufacturer participates in the Medicaid Drug Rebate Program, visit the CMS website below to verify that the first five digits of the NDC number (labeler code) are listed as a participating drug company:

http://www.cms.hhs.gov/MedicaidDrugRebateProgram/10_DrugComContactInfo.asp

(6) 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 client per week;

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

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

Stat. Auth.: 413.042

Stats. Implemented: ORS 414.025 and 414.065

07-01-09

7-1-10 (Hk)

7-1-11 (Hk)

410-130-0190 Tobacco Cessation

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

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

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

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

(c) Assess – the tobacco user's willingness to attempt to quit using tobacco within 30 days;

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

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

(3) When providing basic treatment, include a brief discussion to address client concerns and provide the support, encouragement, and counseling needed to assist with tobacco cessation efforts. These brief interventions, less than 6 minutes, generally are provided during a visit for other conditions, and additional billing is not appropriate.

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

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

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

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

(c) Individual or group counseling, six minutes or greater.

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

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

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

(c) Enter proper documentation of the service in the client's chart.

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

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

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

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

8-01-08

2-1-10 (Stat lines only)

7-1-10 (Hk-Stats)\

7-1-11 (Hk)

410-130-0200 Prior Authorization

(1) For fee-for-service clients prior authorization (PA) is required for all procedure codes listed in Table 130-0200-1 regardless of the setting they are performed in. For details on where to obtain PA: download a copy of the Medical-Surgical Services Supplemental Information booklet at: http://www.dhs.state.or.us/policy/healthplan/guides/medsurg/med-surgsupp1109.pdf

(2) For clients enrolled in a prepaid health plan (PHP), providers must obtain PA from the client's PHP.

(3) PA is not required:

(a) For clients with both Medicare and Medical Assistance Program coverage and the service is covered by Medicare. However, PA is still required for bariatric surgeries and evaluations and most transplants, even if they are covered by Medicare;

(b) For kidney and cornea transplants, unless they are performed out-of-state;

(c) For emergent or urgent procedures or services;

(d) For hospital admissions, unless the procedure requires PA.

(4) A second opinion may be requested by the Division of Medical Assistance Programs or the contractor before PA is given for a surgery.

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

(6) Refer to Table 130-0200-1 for all services/procedures requiring PA.

(7) Table 130-0200-1

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

1-1-11

7-1-11 (Hk)

Table 130-0200-1 Prior Authorization

For numbers followed by (* #) see bottom of table for additional information.

00580	21280	33944-33945 (*2)
00796	22554	33976
00938	22556	33979
11960	22558	38204-38215 (*2)
11970	22585	38230 (*2)
15822	22590	38240 (*2)
15823	22595	38241 (*2)
17106-17108 (*1)	22600	40840
20910	22610	40842-40845
21050	22612	43631-43634
21120	22614	44135 (*2)
21121	22630	43644-43645 (*5)
21137-21139	22632	43770-43771 (*5)
21141-21143	22800	43773 (*5)
21145-21147	22802	43846-43848 (*5)
21150	22804	44715-44721 (*2)
21151	22808	47135 (*2)
21154	22810	47136 (*2)
21155	22812	47140-47147 (*2)
21159	22841-22848	48160 (*2)
21160	22851	48551-48552 (*2)
21172	23472	48554 (*2)
21175	26560-26562	48556 (*2)
21179-21184	27447	49000 (*3)
21188	28340	49329
21193-21196	28341	51840
21198	28344	51841
21199	28345	51845
21206	30400	54360
21208	30410	54400
21209	30420	54401
21256	30430	54405
21260	30435	54408
21261	30450	54410
21263	30460	54411
21267	30462	54416
21268	32851-32856 (*2)	54417
21270	33933 (*2)	56805
21275	33935 (*2)	57267

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57288
57291
57292
57335
58150
58152
58180
58260
58262-58263
58267
58270
58275
58280
58285
58290-58294
58400
58410
58541-58544
58548
58550
58552-58554
58570-58573
58660
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58673
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58940
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63005
63011-63012
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63101-63103
63170
63172-63173
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63191
63194-63200
63250-63252
63265-63268
63270-63273
63275-63278
63280-63283
63285-63287
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63300-63308
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67900-67904
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67911
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67914-67917
78459
78491
78492
78608
78609
78811-78816
92507
S2053 (*2)
S2065 (*2)
S2118
S2142 (*2)
S2150 (*2)
S2350
S2351
70450
70460
70470
70551
70553
71250
71260
72141
72148
72156
72158

72192	73222	74150
72193	73721	74160
72194	73722	74170
73221	73723	

(*1) Authorized for facial lesions only, if meets other PA requirements
(*2) Contact the Medical Director's Office
(*3) PA required if an elective procedure
(*4) PA not required for clients under age 21
(*5) Primary Care Provider (PCP) must refer for evaluation PA pursuant to Prioritized List guidelines.

410-130-0220 Not-Covered/Bundled Services

(1) Refer to the Oregon Health Plan administrative rules (chapter 410, division 141) and General Rules (chapter 410, division 120) for coverage of services. Refer to Table 130-0220-1, in this rule, for additional information regarding not-covered services or for services that the Division of Medical Assistance Programs (Division) considers to be bundled.

(2) The following are examples of not-covered services. This is not an all-inclusive list:

(a) Psychotherapy services (covered only through local mental health clinics and Mental Health Organizations);

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

(c) Services that are normally provided in the practitioner's office but at the client's request are provided in a location other than the practitioner's office.

(d) Telephone calls for purposes other than tobacco cessation, maternity case management and telemedicine.

(3) For specific information, see General Rules OAR 410-120-1200, Medical Assistance Benefits: Excluded Services and Limitations.

(4) Table 130-0220-1

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414-065

7-1-10

7-1-11 (Hk)

Table 130-0220-1 Not Covered/Bundled Services

Refer to the current Oregon Health Service's Commission's Prioritized List of Health Services for coverage of codes depending on code pairings and line placements.

Refer to the Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Rules (division 410, chapter 122) for not covered Heathcare Common Procedure Coding System (HCPCS) codes not addressed below.

BND = bundled services that are included in the base service

0001F-7025F	22864	37210
0016T-0207T	22865	38129
00802	27080	41530
11980	28890	41821
15819-15821	29866-29868	43257
15824-15826	31620	43647
15928	31627	43648
15929	32491	43842
19316	32850 BND	43843
20696	32998	43881
20697	33140	43882
20979	33141	43886-43888
29082	33282	44132 BND
21685	33548	44133 BND
22523-22525	33930 BND	44979
22856	33940 BND	45391
22857	33968	45392
22861	36455	46505
22862	36521	46938

47133 BND
48550 BND
50380
50592
53850
53852
55300
55873
55970
55980
58740 BND
59897
61635

62263
62290-62292

64479
64480
64490-64495
64626
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69090
69720
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70555
74261-74263
74742
75571
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76376
76377
77083
77084
77373
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78491
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82107
82610
82757
83037
83631
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83701
83704
83913
83951
83987
83993
84145

84431
84830
86305
86356
86891 BND
86910
86911
88000-88099
88384-88386
88738
88740
88741
89235
89250-89398
90665
90690-90693
90712
90717
90725
90727
90735
90738
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91038
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91111
91120
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96116
99119
96120
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97005
97006
97010 BND
97016
97018
97024
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97139
97532
97533
97605
97606
97537
97770
99000-99002 BND
99024 BND
99026
99027
99053
99056
99070 (*1)
99071 BND
99075
99080
99082
99090
99091
99100 BND
99116 BND
99135 BND
99140 BND
99174
99360 (*3)
99367
99368
99371-99373
99450
99455
99456
99500-99602 (*5)
A4570 (*4)
A4580 (*4)
A4590 (*4)
A4641
G0166
G0168
G0219
G0252
M0076
M0100
M0300-M0301
P2028-P2029
P2031
P2033
P2038
P7001
P9010-P9060
Q0035
Q0091 BND

Q0092 BND
Q0115

(*1) Use HCPCS
(*2) Not covered for ages 21 and older
(*3) Covered only for standby at cesarean/high-risk delivery of newborn
(*4) Use Q4001-Q4051
(*5) Refer to Home Health Program Rules

410-130-0225 Teaching Physicians

(1) Supervising faculty physicians in a teaching hospital may not bill the Division of Medical Assistance Programs (Division) on a CMS-1500 or 837P when serving as an employee of the hospital during the time the service was provided or when the hospital reports the service as a direct medical education cost on the Medicare and Division cost report.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

1-1-07

2-1-10 (Stat lines only)

7-1-10 (Hk-Stat lines)

7-1-11 (Hk)

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 a CAF, SPD, AMH, OYA, SCF branch office or approved by the Division of Medical Assistance Programs (Division). The branch office may request an administrative medical examination or a medical report (DMAP 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 413.042

Stats. Implemented: ORS 414.025, 414.065

1-1-07

2-1-10 (Stat lines only)

7-1-10 (HK – Stat lines)

7-1-11 (Hk)

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 (an acupuncturist under the physician's supervision) or a licensed acupuncturist, and billed using CPT 97810-97814.

(3) Chiropractic services must be billed using 99202 and 99212 for the diagnostic visits and 98940-98942 for manipulation. Bill laboratory and radiology services with specific Current Procedural Terminology (CPT) codes.

(4) Maternity care and delivery:

(a) Use Evaluation and Management (E/M) codes when providing three or fewer antepartum visits;

(b) For births performed in a clinic or home setting, use CPT codes that most accurately describe the services provided. Healthcare Common Procedure Coding System (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;

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

(d) 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 obstetrical care with cesarean delivery of twins, bill 59510 for the first delivery and 59514 for the second delivery.

(5) Mental health and psychiatric services:

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

(b) Psychiatrists can be reimbursed by the Division of Medical Assistance Programs (Division) 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.

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

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

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

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

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

(8) 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 the DMAP contractor. Refer to the Vision Program Rules for more information.

(9) Speech & Hearing:

(a) HCPCS codes V5000-V5299 are limited to speech-language pathologists, audiologists, and hearing aid dealers;

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

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

(d) CPT 92593 and 92595 are only covered for children under age 21.

(10) Massage therapy is covered only when provided with other modalities during the same physical therapy session. Refer to Physical and Occupational Therapy Services administrative rules (chapter 410 division 131) for other restrictions.

(11) Medical practitioners may apply topical fluoride varnish during a medical visit to children under the age of 7 years who have limited access to a dental practitioner. Refer to Dental Services rule (410-123-1260).

Statutory Authority: ORS Chapter 413.042

Statutes Implemented: 414.025 and 414.065

7-1-09

7-1-10 (Hk)

7-1-11 (Hk)

410-130-0245 Early and Periodic Screening, Diagnostic and Treatment 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 Oregon Health Plan (OHP) Plus 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 OHP OAR 410-141-0000, Definitions;

(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 Current Procedural Terminology (CPT) and Health care Common Procedure Coding System (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, Addictions and Mental Health Division (AMH), 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 or 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 for lead poisoning. 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 Risk Assessment Questionnaire (DMAP form 9033) and/or blood lead tests as indicated.

(5) Lead Risk Assessment Questionnaire: Complete the Lead Risk Assessment Questionnaire (DMAP form 9033) found in the Medical-Surgical Services Supplemental Information. Beginning at 1 year of age, the questionnaire must be used at each EPSDT exam to assess the potential for lead exposure. Retain this questionnaire in the client's medical record. Do not attach the DMAP 9033 form to the claim for reimbursement. The Division does not stock this form; photocopy the form and the instructions from the Medical-Surgical Services Supplement Information.

(6) Blood Lead Testing: Any "yes" or "don't know" answer in Part B, questions 1-8 on the Lead Risk Assessment Questionnaire (DMAP 9033) means that the child should receive a screening blood lead test. An elevated blood lead level is defined as greater than or equal to 10 µg/dL. Children with an elevated blood lead screening test should have a confirmatory blood lead test performed according to the schedule described in Table 130-0245-1 of this rule. If the confirmatory 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 confirmatory blood lead test are described in Table 130-0245-2 and section (7) of this rule.

(7) Children with a confirmatory blood lead level test of greater than or equal to 10 µg/dL are eligible for a one-time comprehensive environmental lead investigation, not including laboratory analysis, of the child’s home. The child may also receive follow-up case management services.

(a) The investigation of the child’s home and follow-up case management services must be provided by a Division-enrolled medical-surgical provider who has received Oregon Public Health Division training to perform these services. Refer to Medical-Surgical Services rule 410-130-0000 for a list of the medical-surgical providers the Division enrolls.

(b) To bill for these services, use HCPCS code T1029. Payment for code T1029 includes the home investigation and any follow-up case management services provided after the home investigation is

completed. The Division limits reimbursement of T1029 to one time per dwelling. For clients enrolled in managed care plans, the service is payable by the Division; do not bill the managed care plan.

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

(9) 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 of this rule.

(10) Table 130-0245-1

(11) Table 130-0245-2

(12) Table 130-0245-3

(13) Table 130-0245-4

(14) Table 130-0245-5

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.150

7-1-10

7-1-11 (Hk)

Table 130-0245-1 Schedule For Confirmatory Testing

The following is the schedule for confirmatory testing of a child with an elevated Blood Lead Level (BLL) on a screening test. Providers should refer to current Oregon Public Health Division guidance.

Screening test (µg/dL) result is:	Perform confirmatory test on venous blood within:
10- 19	30 days
20-44	7 days*
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 confirmatory testing.

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

Confirmatory testing – the first venous (venipuncture) blood lead test performed within 6 months on a child who has previously had an elevated BLL on a screening test.

Table 130-0245-2 Comprehensive Follow-up Services

Confirmatory 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 elevated BLLs persist (i.e., 2 venous elevated BLLs in this range at least 3 months apart) or worsen, proceed according to actions for elevated 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.
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 aconfirmatory test result of 10 µg/dL, should be every 3 months until two consecutive test results are each < 10 µg/dL.

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 (DMAP 9033) is administered.

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

- Hazards of lead-based paint in homes built before 1950.
- 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.

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 an elevated blood lead level (EBLL).

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 the environmental inspection, if applicable, will be mailed to the health-care provider and the family by the 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. The LeadLine can 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) The Division of Medical Assistance Programs (Division) covers Synagis (palivizumab-rsv-igm) only for high-risk infants and children as defined by the American Academy of Pediatric guidelines. Bill 90378 for Synagis.

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

(4) VFC Program:

(a) Under this federal program, vaccine serums are free for clients' ages 0 through 18. The Division will not reimburse the cost of privately purchased vaccines that are provided through the VFC Program. The Division also will not reimburse for the administration of privately purchased vaccines;

(b) Only providers enrolled in the VFC Program can receive free vaccine serums. To enroll as a VFC provider, contact the Public Health Immunization Program. For contact information, see the Medical-Surgical Supplemental Information found at http://www.dhs.state.or.us/policy/healthplan/guides/medsurg/med-surgsupp1109.pdf

(c) The Division will reimburse providers for the administration of any vaccine provided by the VFC Program. Whenever a new vaccine becomes available through the VFC Program, administration of that vaccine is also covered by the Division;

(d) Refer to Table 130-0255-1 for immunization codes provided through the VFC Program. Recommendations as to who may receive influenza vaccines vary from season to season and may not be reflected in Table 130-0255-1;

(e) Providers shall follow the current Advisory Committee on Immunization Practices (ACIP) guidelines for immunization schedules. Exceptions include:

(A) On a case-by-case basis, provider may use clinical judgment in accordance with accepted medical practice to provide immunizations on a modified schedule;

(B) On a case-by-case basis, provider may modify immunization schedule in compliance with the laws of the State of Oregon, including laws relating to exemptions for immunizations due to religious beliefs or other requests.

(f) Use the following procedures when billing for the administration of a VFC vaccine:

(A) When the sole purpose of the visit is to administer a VFC vaccine, the provider should bill the appropriate vaccine procedure code with modifier -26 or -SL for each injection. Do not bill Current Procedural Terminology (CPT) code 90465-90474 or 99211;

(B) When the vaccine 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.

Table 130-0255-1

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

1-1-11

7-1-11 (Hk)

Table 130-0255-1 Vaccines for Children

90632 (*1)	90669	90715
90633	90670	90716
90636 (*1)	90680	90721 (*2)
90647	90681	90723
90648	90696	90732
90649	90698	90733
90650	90700	90734
90655	90702	90744
90656	90707	90748
90657	90710	
90658	90713	
90660	90714	

(*1) Age 18 only.

(*2) Bill when 90700 and 90648 are given combined in one injection.

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 Division of Medical Assistance Programs' Medical-Surgical Services or Dental Services rules. Reimbursement is made at all-inclusive global rates based on the surgical procedure codes billed.

(2) If the client has Medicare in addition to Medicaid and Medicare covers a surgery, but not in an ASC setting, then the surgery may not be performed in an ASC.

(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 client's use of the ASC's or BC's facilities including the operating room and recovery room;

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

(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 registered nurse anesthetists, dentists, podiatrists and Licensed Direct Entry Midwives (for birthing centers only);

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

(c) Prosthetic and orthotic 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 the Division 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 the Division.

(6) Procedure coding for non-Birthing Centers:

(a) Bill the same procedure codes billed by the surgeon;

(b) For reduced or discontinued procedures, use Common Procedural Terminology (CPT) instructions and add appropriate modifiers;

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

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

(7) Procedure coding for Birthing Centers:

(a) Bill code 59409 only once for a single vaginal delivery regardless of the total days that the client was in the facility for labor management, delivery and immediate postpartum care;

(b) For delivery of twins:

(A) Bill the delivery of the first twin with 59409; and

(B) Bill the delivery of the second twin with code 59409 on a separate line;

(c) When labor was managed in the BC but a delivery did not result, bill S4005 (Interim labor facility global) and attach a report documenting the circumstances.

(8) Prior authorization is required for all services listed in Table 130-0200-1. Refer to Rule 410-130-0200.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

07-01-09

7-1-10 (Hk)

7-1-11 (Hk)

410-130-0368 Anesthesia Services

(1) Anesthesia is not covered for procedures that are below the funding line on the Health Services Commission's Prioritized List of Health Services (see OAR 410-141-0520).

(2) 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, except for anesthesia for neuraxial labor analgesia/anesthesia/anesthesia (code 01967). See item 3 below for reporting neuraxial labor analgesia/anesthesia.

(a) For anesthesia services billed (excluding OB code 01967), do not bill the "base units" plus "time units" as the total quantity of service units. (The Division of Medical Assistance Programs (Division) will automatically calculate the base units for the billed anesthesia code using current year ASA listing of base units.)

(b) Bill only, the total quantity of time units on one line. 1 unit of time equals one 15minute increment of anesthesia time: (For example, 1 hour (60 minutes) equals 4 units of anesthesia time.) The Division will then add the billed time units to the anesthesia code base units to determine total units for payment.

(C) For the last fraction of time less than 15 minutes, bill one unit for 8-14 minutes. Do not bill a unit for 1-7 minutes of time.

(3) Anesthesia for neuraxial labor analgesia/anesthesia (01967) will be paid at a flat rate. The Division will disregard the number of units in the unit field and pay a flat rate/unit of one. OB Services that do not include labor (i.e. 01958-10966) and code billed in conjunction with 01967 (i.e. 01968 and 01969) should be reported with the appropriate time units only (see item 2b above).

(4) 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.

(5) A valid consent form is required for all hysterectomies and sterilizations.

(6) 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.

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

Statutory Authority: ORS Chapter 413.042

Statutes Implemented: 414.025 and 414.065

7-1-07

2-1-10 (Stat lines only)

7-1-10 (Hk-Stats)

7-1-11 (Hk)

410-130-0380 Surgery Guidelines

(1) The Division of Medical Assistance Programs (Division) 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 administrative rules 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 the Division maximum fee for that procedure;

(b) Second and third procedure paid at 50% of the Division maximum fee;

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

(d) Endoscopic procedures paid at 100% of the Division maximum fee for the primary level procedure. The Division 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 413.042

Stats. Implemented: ORS 414.025, 414.065

1-1-07
2-1-10 (Stat lines only)
7-1-10 (Hk-Stats)

7-1-11 (Hk)

410-130-0562 Abortion

(1) 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 (a Division of Medical Assistance Programs (Division) modifier) for surgical abortion related services.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.125, 414.065

1-1-07

2-1-10 (Stat lines only)

7-1-10 (Hk-Stats)

7-1-11 (Hk)

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 (DMAP 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 form 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:

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.

(6) Do not use the Consent to Sterilization form (DMAP 742A or B) for hysterectomies.

(7) Submit a copy of the Hysterectomy consent form with the claim.

(8) Sterilization Male & Female: A copy of a properly completed Consent to Sterilization form (DMAP 742 A or B), 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 Division for all sterilizations. The original consent form must be retained in the clinical records. Prior authorization is not required.

(9) 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) Ages 15 years or older who are mentally competent to give informed consent:

(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 it is signed and dated by the person obtaining 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 sterilization is performed. 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 client 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 client 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.

(10) Involuntary Sterilization -- Clients who lack the ability to give informed consent and are 18 years of age or older:

(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.

(11) Submit the Consent to Sterilization Form (DMAP 742 A or B) along with the claim. The Consent to Sterilization form must be completed in full:

(a) Consent forms submitted to the Division without signatures and/or dates of signature by the client or the person obtaining consent are invalid;

(b) The client and the person obtaining consent may not sign or date the consent retroactively;

(c) The performing physician must sign the consent form. The date of signature must be either the date the sterilization was performed or a date following the sterilization.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

1-1-11

7-1-11 (Hk)

410-130-0585 Family Planning Services

(1) Family planning services are those intended to prevent or delay pregnancy, or otherwise control family size.

(2) The Division of Medical Assistance Programs (Division) covers family planning services for clients of childbearing age (including minors who are considered to be sexually active).

(3) Family Planning services include:

(a) Annual exams;

(b) Contraceptive education and counseling to address reproductive health issues;

(c) Laboratory tests;

(d) Radiology services;

(e) Medical and surgical procedures, including tubal ligations and vasectomies;

(f) Pharmaceutical supplies and devices.

(4) Clients may seek family planning services from any provider enrolled with the Division, even if the client is enrolled in a Prepaid Health Plan (PHP). Reimbursement for family planning services is made either by the client's PHP or the Division. If the provider is:

(a) A participating provider with the client's PHP, bill the PHP;

(b) An enrolled Division provider, but is not a participating provider with the client's PHP, bill the Division and add modifier –FP to the billed code.

(5) Family planning methods include natural family planning, abstinence, intrauterine device, cervical cap, prescriptions, sub-dermal implants, condoms, and diaphragms.

(6) Bill all family planning services with the most appropriate ICD-9-CM diagnosis code in the V25 series or V26.41-V26.49 (Contraceptive Management), the most appropriate CPT or HCPCS code and add modifier –FP.

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

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

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

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065, 414.025, 414.152

1-1-11

7-1-11 (Hk)

410-130-0587 Family Planning Clinic Services

(1) This rule pertains only to Family Planning Clinics.

(2) To enroll with the Division of Medical Assistance Programs (Division) as a family planning clinic, a provider must also be enrolled with the Office of Family Health as an Oregon Contraceptive Care (CCare) provider.

(3) Family planning clinics must follow all applicable CCare and the Division rules.

(4) The Division will reimburse family planning clinics an encounter rate only when the primary purpose of the visit is for family planning.

(5) 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 contraceptive medications;

(F) Contraceptive injections.

(b) Do not bill procedures, such as IUD insertions, diaphragm fittings or injections, with CPT or 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.

(6) Reimbursement for T1015 does not include payment for family planning (FP) supplies and medications:

(a) Bill contraceptive supplies and contraceptive medications separately using HCPCS codes. Where there are no specific HCPCS codes, use an appropriate unspecified HCPCS code:

(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) Bill all contraceptive supplies and contraceptive medications at acquisition cost;

(c) Add modifier -FP after all codes for contraceptive services, supplies and medications;

(d) Non-contraceptive medications are not billable under this program.

(7) Reimbursement for T1015 does not include payment for 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 an FP encounter;

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

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

(9) When billing providers who are not participants in a Prepaid Health Plan (PHP) for services provided to clients enrolled in a PHP, add modifier –FP to the billed code.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.152

1-1-11

7-1-11 (Hk)

410-130-0595 Maternity Case Management

This rule is in effect for services rendered retroactive to July 1, 2009.

(1) Providers may submit claims retroactively for services provided on or after July 1, 2009, if they meet the following criteria:

(a) The provider was appropriately licensed, certified and otherwise met all Division of Medical Assistance Programs (Division) requirements for providers at the time services were provided; and

(b) Services were provided less than 12 months prior to the date of first claim submission and were allowable services in accordance with this rule; and

(c) Documentation regarding provider qualifications and the services that the provider retroactively claims must have been available at the time the services were provided.

(d) The Division will not allow duplicate payments to be made to the same or different providers for the same service for the same client, nor will payment be allowed for services for which third parties are liable to pay. (See also OAR 410-120-1280 in the General Rules Program.) The Division will recoup all duplicate payments.

(2) The primary purpose of the Maternity Case Management (MCM) program is to optimize pregnancy outcomes, including reducing the incidence of low birth weight babies. MCM services are tailored to the individual client needs. These services are provided face-to-face throughout the client's pregnancy, unless specifically indicated in this rule.

(3) 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 billing of intensive nutritional counseling services.

(4) 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.

(5) Only one provider at a time may provide MCM services to the client. The provider must coordinate care to ensure that duplicate claims for MCM services are not submitted to the Division.

(6) Definitions:

(a) Case Management -- An ongoing process to assist and support an individual pregnant client in accessing necessary health, social, economic, nutritional, and other services to meet the goals defined in the Client Service Plan (CSP)(defined below);

(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, address the CSP and provide an on-going relationship development between the client and the visiting provider.

(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 (defined below) and includes a client discharge plan/summary;

(d) High Risk Case Management -- Intensive level of 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 -- A client who has a current (within the last year) documented alcohol, tobacco or other drug (ATOD) abuse history, or

who is 17 or under, or has other conditions identified in the Initial Assessment or during the course of service delivery;

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

(h) Nutritional Counseling -- Intensive nutritional counseling for clients who have at least one of the conditions listed under Nutritional Counseling (15)(a)(A-I) in this rule;

(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).

(7) Maternity case manager qualifications:

(a) Maternity case managers must be currently licensed as a:

(A) Physician;

(B) Physician assistant;

(C) Nurse practitioner;

(D) Certified nurse midwife;

(E) Direct entry midwife;

(F) Social worker; or

(G) Registered nurse;

(b) The maternity case manager must be a Division enrolled provider or deliver services under an appropriate Division enrolled provider. See provider qualifications in the Division's General Rules 410-120-1260.

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

(d) Other paraprofessionals may provide specific services with the exclusion of the Initial Assessment (G9001) while working under the supervision of one of the practitioners listed above in this section;

(e) The maternity case manager must sign off on all services delivered by a paraprofessional;

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

(8) Nutritional counselor qualifications -- nutritional counselors must be:

(a) A licensed dietician (LD) licensed by the Oregon Board of Examiners of Licensed Dieticians; and

(b) A registered dietician (RD) credentialed by the Commission on Dietetic Registration of the American Dietetic Association (ADA).

(9) Documentation requirements:

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

(b) A correctly completed Division form 2470, 2471, 2472 and 2473 or their equivalents meet minimum documentation requirements for MCM services.

(10) G9001 -- Initial Assessment must be performed by a licensed maternity case manager as defined under (7)(a)(A-G) in this rule:

(a) Services include:

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

(B) Development of a CSP that addresses identified needs;

(C) Making and assisting with referrals as needed to:

(i) A prenatal care provider;

(ii) A dental health provider;

(D) Forwarding the initial assessment and the CSP to the prenatal care provider;

(E) Communicating pertinent information to the prenatal care provider and others participating in the client's medical and social care;

(b) Data sources relied upon 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;

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

(d) The Initial Assessment (G9001) is billable once per pregnancy per provider and must be performed before providing any other MCM services. Only a Home/Environmental Assessment (G9006) and a Case Management Visit (G9012) may be performed and billed on the same day as an Initial Assessment.

(11) 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 includes 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) Care coordination as follows:

(A) Contact with Oregon Health Authority (Authority) case worker, if assigned;

(B) Maintain contact with prenatal care provider to ensure service delivery, share information, and assist with coordination;

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

(d) Linkage to client services indicated in the CSP:

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

(B) Provide linkage to labor and delivery services;

(C) Provide linkage to family planning services as needed; (e) Ongoing nutritional evaluation with basic counseling and referrals to nutritional counseling, as indicated;

(e) Utilization and documentation of the “5 A’s” brief intervention protocol for addressing tobacco use (US Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence, 2008). Routinely:

(A) Ask all clients about smoking status;

(B) Advise all smoking clients to quit;

(C) Assess for readiness to try to quit;

(D) Assist all those wanting to quit by referring them to the Quitline and/or other appropriate tobacco cessation counseling and provide motivational information for those not ready to quit;

(E) Arrange follow-up for interventions;

(f) Provide training and education on all mandatory topics - Refer to Table 130-0595-2 in this rule;

(g) Provide client advocacy as necessary to facilitate access to benefits or services;

(h) Assist client in achieving the goals in the CSP;

(i) G9002 is billable after the delivery when more than three months of service were provided. Services must be initiated during the prenatal period and carried through the date of delivery;

(j) G9002 is billable once per pregnancy.

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

(a) Can be billed when the CSP has been developed and MCM services were initiated during the prenatal period and partially completed;

(b)MCM services are provided to the client for three months or less.

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

(a) Enhanced level of services that are more intensive and are provided in addition to G9002;

(b) High Risk Case Management services are provided for the client for more than three months after the client was identified as high risk; and(c) Client is provided at least eight Case Management Visits;

(d) G9005 is billable after the delivery and only once per pregnancy;

(e) G9005 can be billed in addition to G9002.

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

(a) Are the same enhanced level of services provided in G9005 but the client became 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) Are high risk case management services provided to the client for three months or less after the client has been identified as high risk; or (c) Is billed when the client is provided less than eight Case Management Visits;

(d) G9010 is billable after the delivery and once per pregnancy;

(e) G9010 can be billed in addition to G9002 or G9009.

(15) S9470 -- Nutritional counseling:

(a) Is available for clients who have at least one of the following conditions:

(A) Chronic disease such as diabetes or renal disease;

(B) Hematocrit (Hct) less than 34 or hemoglobin (Hb) less than 11 during the first trimester, or Hct less than 32 or Hb less than 10 during the second or third trimester;

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

(D) Pregnancy weight gain outside the appropriate Women, Infants and Children (WIC) guidelines;

(E) Eating disorder;

(F) Gestational diabetes;

(G) Hyperemesis;

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

(I) Other identified conditions;

(b) Documentation must include all of the following:

(A) Nutritional assessment;

(B) Nutritional care plan;

(C) Regular client follow-up;

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

(d) S9470 is billable only once per pregnancy.

(16) G9006 -- Home/Environmental Assessment:

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

(b) G9006 may be billed only once per pregnancy, except an additional Home/Environmental Assessments may be billed with

documentation of problems which necessitate follow-up assessments or when a client moves. Documentation must be submitted with the claim to support the additional Home/Environment Assessment.

(17) 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) G9011 is billable in lieu of a Case Management Visit and counted towards the total number of Case Management Visits (see G9012 for limitations).

(18) G9012 – Case Management Visit:

(a) Each Case Management Visit must include:

(A) An evaluation and/or revision of objectives and activities addressed in the CSP: and

(B) At least two training and education topics listed in Table 130-0595-2 in this rule;

(b) Four Case Management Visits (G9012) may be billed per pregnancy. Telephone Case Management Visits (G9011) are included in this limitation;

(c) Six additional Case Management Visits may be billed if the client is identified as high risk;

(A) These additional visits may not be billed until after delivery;

(B) These additional six visits may only be submitted with or after High Risk Full (G9005) or High Risk Partial (G9010) Case Management has been billed. Telephone Case Management Visits (G9011) are included in this limitation;

(d) Maternity Case Management Visits (G9012) may be provided in the client's home or other site.

(19) Table 130-0595-1

(20) Table 130-0595-2

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

4-15-10 (T) 9-1-10 (P)

7-1-11 (Hk)

Table 130-0595-1 Environmental Assessment

Housing Characteristics
Location of home and proximity to exposures
General assessment and condition of home as shelter
Number of bedrooms and number of persons
Heating and cooling
Ventilation and windows
Locking entrance
Phone service
Running/potable water
Access to bathroom
Sanitation/sewage and garbage

General Safety
Guns/weapons: locked and unloaded
Lighting adequate for safety
Fall/Trip hazards
Temperatures of hot tubs and hot water tanks
Non-slip shower and bath surfaces

Food Safety
Food preparation facilities
Refrigeration
Cleanable surfaces
Food storage facilities
Health adequacy: safety and sanitation

Toxins/Teratogens
Pesticides
Lead exposure: peeling paint, lead pipes and lead dust
Household cleaners

Indoor Air
Tobacco smoke – second- and third-hand
Wood/Pellet stoves
Mold and mildew
Carbon monoxide risk
Chemical use: in or near home
Radon risk

Asbestos
Pollutants: air fresheners, candles, plug-ins and incense

Fire Prevention
Fire hazards: smoking, candles and flammable item storage
Electrical outlets

Emergency Planning
Smoke alarms: installed and working
Adequate exits: all locations and free of obstacles
Emergency preparedness: escape plan; emergency numbers posted; adequate food, water and supplies; alternate heating, lighting and cooking capability
Transportation

Occupations & Hobbies
Employment, such as: nail salons, painters, remodelers, home repair, radiator repair, dry cleaning, gardener, pesticide applicator, farm/orchard worker, landscape worker
Hobbies, such as: making and using fishing weights or bullets; shooting or cleaning at indoor shooting ranges

Miscellaneous
Pets: presence or care of dogs, cats, birds, reptiles (lizards & snakes) and turtles
Cleaning of cat litter box and other pet cages
Administering flea or tick treatments to pets
Pests: presence or management of mice, rats, insects, bedbugs, etc.

Table 130-0595-2 MCM Training and Education Topics

MANDATORY TOPICS
Alcohol, tobacco and other drug exposure
Maternal oral health
Breastfeeding promotion
Perinatal mood disorders
Prematurity and pre-term birth risks
Maternal/Fetal HIV (Human Immunodeficiency Virus) and Hepatitis B transmission
Nutrition, healthy weight and physical activity
Intimate Partner Violence (IPV)

NON-MANDATORY TOPICS

Pregnancy and Childbirth
Common discomforts and interventions
Labor and birth process
Coping strategies
Relationship changes
Stress reduction
Pregnancy danger signs and symptoms
Fetal growth and development
Safety in automobiles: proper use of seat belts and infant car seats
Other emergencies

Health Status
Medications
Digestive tract changes
Food availability
Food selection and preparation
Mercury consumption from eating fish
Other existing health conditions during pregnancy

Environmental Health
Housing
Safety and sanitation
Toxins/Teratogens
Occupational exposures
Drinking water

Non-fluoridated water community
Home cleaning supplies
Tobacco smoke exposure
Asthma triggers
Lead exposure and screening

Parenting
Infant care
Early childhood caries prevention
Nutrition, feeding and infant growth
Infant sleep patterns and location
SIDS (Sudden Infant Death Syndrome) and "Back to Sleep"
Infant developmental milestones
Immunizations and well child care
Infant/Parent interaction
Bonding and attachment
Infant communication patterns and cues
Parental frustration and sleep deprivation
Child nurturing, protection and safety

Other Topics
Individual and family emergency preparedness
Family planning
Sexually transmitted diseases
Inter-conception and pre-conception health
Community resources
Obtaining accurate health information

410-130-0610 Telemedicine

(1) For the purposes of this rule, telemedicine is defined as the use of medical information, exchanged from one site to another, via telephonic or electronic communications, to improve a patient's health status.

(2) Provider Requirements:

(a) The referring and evaluating practitioner must be licensed to practice medicine within the state of Oregon or within the contiguous area of Oregon and must be enrolled as a Division of Medical Assistance Programs (Division) provider.

(b) Providers billing for covered telemedicine services are responsible for the following:

(A) Complying with HIPAA and/or Oregon Health Authority (Authority) (OHA) Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records requirements. Examples of applicable OHA rules are Confidentiality and Privacy and Financial, Clinical and other record Rules include: OAR 943-120-0170, 410-120-1360, and 410-120-1380, and OAR 943 Division 14. Examples of federal and state privacy and security laws that may apply include HIPAA, if applicable and 42 CFR Part 2, if applicable and ORS 646A.600 to 646A.628 (Oregon Consumer Identity Theft Protection Act);

(B) Obtaining and maintaining technology used in the telemedicine communication that is compliant with privacy and security standards in HIPAA and/or Department Privacy and Confidentiality Rules described in subsection (A).

(C) Ensuring policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records (whether oral or recorded in any form or medium) to unauthorized persons.

(D) Complying with the relevant Health Service Commission (HSC) practice guideline for telephone and email consultation.

(E) Maintaining clinical and financial documentation related to telemedicine services as required in OAR 410-120-1360.

(3) Coverage for telemedicine services:

(a) The telemedicine definition encompasses different types of programs, services and delivery mechanisms for medically appropriate covered services within the patient's benefit package.

(b) Patient consultations using telephone and online or electronic mail (E-mail) are covered when billed services comply with the practice guidelines set forth by the Health Service Commission (HSC) and the applicable HSC-approved CPT code requirements, delivered consistent with the HSC practice guideline.

(c) Patient consultations using videoconferencing, a synchronous (live two-way interactive) video transmission resulting in real time communication between a medical practitioner located in a distant site and the client being evaluated and located in an originating site, is covered when billed services comply with the Billing requirements stated in (5).

(d) Telephonic codes may be used in lieu of videoconferencing codes, if videoconferencing equipment is not available.

(4) Telephone and E-mail billing requirements: Use the E/M code authorized in the HSC practice guideline.

(5) Videoconferencing billing requirements:

(a) Only the transmission site (where the patient is located) may bill for the transmission:

(A) Bill the transmission with Q3014;

(B) The referring practitioner may bill an E/M code only if a separately identifiable visit is performed. The visit must meet all of the criteria of the E/M code billed.

(C) The referring provider is not required to be present with the client at the originating site.

(b) The evaluating practitioner at the distant site may bill for the evaluation, but not for the transmission (Q3014):

(A) Bill the most appropriate E/M code for the evaluation;

(B) Add modifier GT to the E/M code to designate that the evaluation was made by a synchronous (live and interactive) transmission.

(6) Other forms of telecommunications, such as telephone calls, images transmitted via facsimile machines and electronic mail are services not covered:

(a) When those forms are not being used in lieu of videoconferencing, due to limited videoconferencing equipment access, or

(b) When those forms and specific services are not specifically allowed per the Health Service Prioritized List and Practice Guideline.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

7-01-08

7-1-10 (Hk)

7-1-11 (Hk)

410-130-0670 Death With Dignity

(1) All Death with Dignity services must be billed directly to the Division of Medical Assistance Programs (Division), 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 and 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 must be made on a paper CMS-1500 billing form;

(b) Do not submit a claim for Death with Dignity services electronically or on an 837P;

(c) Claims must be submitted using appropriate CPT or HCPCS codes;

(d) The Division unique diagnosis code PAD-00 must be entered in Field 21 of the CMS-1500 billing form. Do not list any additional diagnosis codes in this field;

(e) Claims must be submitted only on paper to: DMAP, PO Box 992, Salem, Oregon 97308-0992;

(f) Prescriptions must be billed only with the Division unique code 8888-PAID-00. This code must be entered in Field 24D of the CMS-1500. In addition, the actual NDC number of the drug dispensed and the dosage must be listed below the prescription code;

(g) The Division 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 the physician to have the client's written consent to contact and inform the pharmacist of the purpose of the prescription.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

1-1-07

2-1-10 (Stat lines only)

7-1-10 (Hk-Stats)

7-1-11 (Hk)

410-130-0680 Laboratory and Radiology

(1) The following tables list the medical and surgical services that:

(a) Require prior authorization (PA) – OAR 410-130-0200 Table 130-0200-1 (PET scans require PA and are included in the table), and;

(b) Are not covered/bundled – OAR 410-130-0220 Table 130-0220-1.

(2) Newborn screening (NBS) kits and collection and handling for newborn screening (NBS) tests performed by the Oregon State Public Health Laboratory (OSPHL) are considered bundled into the delivery fee and, therefore, must not be billed separately. Replacement of lost NBS kits may be billed with code S3620 with modifier –TC. The loss must be documented in the client's medical record. NBS confirmation tests performed by reference laboratories at the request of the OSPHL will be reimbursed only to the OSPHL.

(3) The Division of Medical Assistance Programs (Division) covers lab tests performed in relation to a transplant only if the transplant is covered and if the transplant has been authorized. See the Division Transplant Services administrative rules (chapter 410, division 124).

(4) All lab tests must be specifically ordered by, or at the direction of a licensed medical practitioner 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 performed by the referring lab.

(6) When billing for lab tests, use the date that the specimen was collected as the date of service (DOS) even if the tests were not performed on that date.

(7) Reimbursement for drawing/collecting or handling samples:

(a) The Division will reimburse providers once per day regardless of the frequency performed for drawing/collecting the following samples:

(A) Blood – by venipuncture or capillary puncture, and;

(B) Urine – only by catheterization.

(b) The Division will not reimburse for the collection and/or handling of other specimens, such as PAP or other smears, voided urine samples, or stool specimens. Reimbursement is bundled in the reimbursement for the exam and/or lab procedures and is not payable in addition to the laboratory test.

(8) Pass-along charges from the performing laboratory to another laboratory, medical practitioner, or specialized clinic are not covered for payment and are not to be billed to the Division.

(9) Only the provider who performs the test(s) may bill the Division.

(10) Clinical Laboratory Improvement Amendments (CLIA) Certification:

(a) The Division will only reimburse laboratory services to providers who are CLIA certified by the Centers for Medicare and Medicaid Services (CMS);

(b) 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;

(c) Providers must notify the Division of the assigned ten-digit CLIA number;

(d) Payment is limited to the level of testing authorized by the CLIA certificate at the time the test is performed.

(11) Organ Panels:

(a) The Division 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) The Division will pay 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) Radiology:

(a) Provision of diagnostic and therapeutic radionuclide(s), HCPCS A9500-A9699, are payable only when given in conjunction with radiation oncology and nuclear medicine codes 77401-79999;

(b) HCPCS codes R0070 through R0076 are covered.

(13) Reimbursement of contrast and diagnostic-imaging agents is bundled in the radiology procedure except for low osmolar contrast materials (LOCM).

(14) Supply of LOCM 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) The Division reimburses only for one interpretation of an emergency room patient's x-ray or EKG. The interpretation and report must have directly contributed to the diagnosis and treatment of the patient;

(b) The Division considers a second interpretation of an x-ray or EKG to be for quality control purposes only and will not be reimbursed;

(c) Payment may 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 413.042

Stats. Implemented: ORS 414.025 and 414.065

8-1-08

7-1-10 (Hk)

7-1-11 (Hk)

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:

(a) Use unlisted HCPCS code;

(b) 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) The Division of Medical Assistance Programs (Division) bundles reimbursement for office surgical suites and office equipment in the reimbursement of surgical procedures.

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

(7) A4000-A9999:

(a) All “A” codes listed in Table 130-0700-1 are covered under this program;

(b) All “A” codes not listed in Table 130-0700-1 must be referred to a Durable Medical Equipment (DME) provider;

(c) Do not use A4570, A4580 and A4590 for splint and cast materials. Use codes Q4001-Q4051;

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

(8) B4000-B9999:

(a) HCPCS codes B4034-B4036 and B4150-B9999 are not covered for medical-surgical providers;

(b) Refer these services to home enteral/parenteral providers.

(9) C1000-C9999 are not covered.

(10) E0100-E1799: DMAP covers only the following DME HCPCS codes 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.

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

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

(13) L0000-L9999:

(a) Refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies program Administrative rules for coverage criteria for orthotics and prosthetics;

(b) Refer to Table 130-0220-1 for a list of “L” codes that are not covered;

(c) 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.

(d) 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.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

1-1-07

2-1-10 (Stat lines only)

7-1-10 (Hk-Stats)

7-1-11 (Hk)

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

A4220	A4565
A4260-A4263	A4649
A4266-A4269	A5051-A5112
A4300	A5500-A5507
A4305-A4320	A5509-A5511
A4322-A4328	A6010-A6011
A4330-A4331	A6021-A6224
A4333-A4346	A6231-A6248
A4348-A4362	A6251-A6259
A4367	A6261-A6262
A4369	A6266-A6404
A4371-A4373	A6421-A6438
A4375-A4385	B4081-B4083
A4387-A4399	B4086
A4404-A4421	E0100-E0116
A4462-A4465	E0191
A4550	E0602
A4561-A4562	E1399