DHS Oregon Department of Human Services

Division of Medical Assistance Programs

Medical-Surgical Services

Rulebook

Includes:

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2) Update Information (changes since last update)

3) Other Provider Resource Information

4) Complete set of Medical-Surgical Services Administrative Rules

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MEDICAL ASSISTANCE PROGRAMS

DIVISION 130

MEDICAL- SURGICAL SERVICES

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Medical-Surgical Program Rulebook Update Information for December 20, 2007

DMAP temporarily amended OAR 410-130-0200 to include coverage and PA requirements for bariatric surgery according to the January 1, 2008, changes to the Health Services Commission's Prioritized List of Health Services that reflect interim modifications and technical changes made since the Centers for Medicare and Medicaid Services (CMS) approval of October 31, 2007. CMS also approved revised, age-appropriate Consent to Sterilization forms reflected in temporary rule OAR 410-130-0580.

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

RB 813 12/20/07

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

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

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Podiatrists;

(c) Acupuncturists;

(d) Licensed Physician assistants;

(e) Nurse practitioners;

(f) Laboratories;

(g) Family planning clinics;

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

(i) Licensed Direct entry midwives;

(j) Portable x-ray providers;

(k) Ambulatory surgical centers;

(l) Chiropractors;

(m) Nutritionists (only maternity case management);

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

(o) Registered Nurse First Assistants;

(p) Certified Nurse Anesthetists.

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

(4) The Medical-Surgical Services rules contain information on policy, special programs, prior authorization, and criteria for some procedures. All 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 at website www.ohpr.state.or.us/hsc/index hsc.htm.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

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 (DMAP) 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.

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1-1-07

410-130-0163 Standard Benefit Package

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

(2) The following services are not covered:

(a) Acupuncture (except for chemical dependency provided through local alcohol/drug treatment providers);

(b) Chiropractic and osteopathic manipulations;

(c) Hearing exams for the sole purpose of determining the need for or the type of hearing aid;

(d) Occupational therapy;

(e) Ophthalmological exams for the purpose of prescribing glasses or contacts and glaucoma screenings;

(f) Physical therapy;

(g) Speech therapy.

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

(4) Refer to Table 130-0163-1 for a list of not covered codes.

Table 130-0163-1

Stat. Auth.: ORS 409

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1-1-07

Table 130-0163-1 Not covered services for Standard Benefit Package

92506-92508
92510
97001-97004
97010
97012
97014
97016
97018
97020
97022
97024
97026
97028
97032-97036
97039
97110
97112
97113
97116
97124
97139
97140
97150
97520
97530
97703
97750
97780
97781
97799
98925-98929
98940-98942

410-130-0180 Drugs

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

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

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

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

(A) J1815-J1816;

(B) J3490;

(C) J7699;

(D) J7799;

(E) J8499;

(F) J8999

(G) J9999;

(H) Include the name of the drug, NDC number, and dosage. (d) Do not bill for local anesthetics. Reimbursement is included in the payment for the tray and/or procedure.

(2) DMAP requires both the NDC number and HCPCS codes for claim submission on the electronic 837P form.

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

(4) Not covered services include:

(a) Laetrile;

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

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

(d) Infertility drugs;

(e) Sodium hyaluronate and Synvisc (J7319).

(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 Prudent Pharmaceutical Purchasing Program -- OAR 410-121-0157.

(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 week per client;

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-07

410-130-0190 Tobacco Cessation

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

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

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

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

(c) Assess – 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 generally are provided during a visit for other conditions, and additional billing is not appropriate.

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

(5) 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.

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

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

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

(c) 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 shall not limit or prescribe services a Prepaid Health Plan provides to clients receiving the Basic Health Care Package.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-130-0200 Prior Authorization/Prior Notification

(1) Prior Authorization (PA):

(a) PA for services provided to clients enrolled in a prepaid health plan (PHP) must be obtained from the appropriate PHP. Contact the PHP for their PA requirements and billing instructions.

(b) PA is not required for services covered by Medicare to clients who have both Medicare and Medical Assistance Program coverage. However, PA is required for most transplants, even if they are covered by Medicare.

(c) PA is not required for kidney and cornea transplants unless they are performed out-of-state.

(d) PA must be obtained from the Division of Medical Assistance Program's (DMAP) Transplant Coordinator for transplants and non-emergent, non-urgent out-of-state services. Refer to the DMAP Transplant Services rules (Chapter 410, Division 124) for further information on transplants and refer to the DMAP General Rules (Chapter 410, Division 120) for further information concerning out-of-state services.

(e) PA must be obtained from the Department of Human Services (DHS) Medically Fragile Children's Unit (MFCU) for services provided to MFCU clients.

(f) PA for services provided to clients enrolled in the fee-for-service (FFS) High Risk Medical Case Managed program must be obtained from the Case Management Contractor shown on the client's Medical Care ID. See the Medical-Surgical Services Supplemental Information guide for details.

(g) PA is required for all procedure codes listed in Table 130-0200-1 in this rule. PA for these procedures must be obtained from the Oregon Medical Professional Review Organization (OMPRO) regardless of the setting they are performed in. A second opinion may be requested by DMAP or OMPRO before PA is given for a surgery;

(h) PA is not required for hospital admissions unless the procedure requires PA;

(i) PA is not required for emergent or urgent procedures or services;

(j) PA must be obtained by the treating and performing practitioners;

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

(2) Prior Notification:

(a) Prior notification is required before performing the following radiology tests:

(A) MRIs;

(B) MRAs;

(C) CTs;

(D) CTAs; and

(E) SPECT scans.

(b) Prior notification is not required when these tests are performed during an emergency department visit or an inpatient stay;

(c) Providers ordering these tests must submit a prior notification form to DMAP prior to the performance of the tests;

(d) Refer to the Medical-Surgical Supplemental Information guide for instructions and forms;

(e) Refer to Table 130-0200-2 for radiology codes requiring prior notification.

Table 130-0200-1

Table 130-0200-2

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

12-20-07

Table 130-0200-1 Prior Authorization

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

00580	21280	33944-33945 (*2)
00796	22554	33979
00938	22556	38204-38215 (*2)
11960	22558	38230 (*2)
11970	22585	38240 (*2)
15822	22590	38241 (*2)
15823	22595	40840
17106-17108 (*1)	22600	40842-40845
20910	22610	43631-43634
21050	22612	44135 (*2)
21120	22614	43644-43848
21121	22630	43770-43774
21137-21139	22632	44715-44721 (*2)
21141-21143	22800	47135 (*2)
21145-21147	22802	47136 (*2)47140-
21150	22804	47147 (*2)
21151	22808	48160 (*2)
21154	22810	48551-48552 (*2)
21155	22812	48554 (*2)
21159	22841-22848	48556 (*2)
21160	22851	49000 (*3)
21172	23472	49320
21175	26560-26562	49329
21179-21184	27447	51840
21188	28340	51841
21193-21196	28341	51845
21198	28344	54360
21199	28345	54400
21206	30400	54401
21208	30410	54405
21209	30420	54408
21256	30430	54410
21260	30435	54411
21261	30450	54416
21263	30460	54417
21267	30462	56805
21268	32851-32856 (*2)	57267
21270	33933 (*2)	57283
21275	33935 (*2)	57284

57288	63035	65150
57291	63040	65155
57292	63042-63048	67311 (*4)
57335	63050-63051	67312 (*4)
58150	63055-63057	67314 (*4)
58152	63064	67316 (*4)
58180	63066	67318 (*4)
58260	63075-63078	67320 (*4)
58262-58263	63081	67331 (*4)
58267	63082	67332 (*4)
58270	63085-63088	67334 (*4)
58275	63090	67335 (*4)
58280	63091	67340 (*4)
58285	63101-63103	67550
58290-58294	63170	67560
58400	63172-63173	67900-67904
58410	63180	67906
58541-58544	63182	67908
58548	63185	67909
58550	63190	67911
58552-58554	63191	67912
58660	63194-63200	67914-67917
58661	63250-63252	78459
58672	63265-63268	78491
58673	63270-63273	78492
58720	63275-63278	78608
58940	63280-63283	78609
62351	63285-63287	78811-78816
63001	63290	92507
63003	63295	S2053 (*2)
63005	63300-63308	S2065 (*2)
63011-63012	65125	S2142 (*2)
63015-63017	65130	S2150 (*2)
63020	65135	S2350
63030	65140	S2351

(*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

Table 130-0200-2 Prior Notification

70450
70460
70470
70480-70482
70486-70488
70490-70492
70496
70498
70540
70542-70549
70551-70553
70557-70559
71250
71260
71270
71275
71550-71552
71555
72125-72133
72141-72142
72146-72149
72156-72159
72192-72198
73200-73202
73206
73218-73223
73225
73700-73702
73706
73718-73723
73725
74150
74160
74170
74175
74181-74183
74185
75552-75556
76070-76071
76355-76370
76400
78205-78206
78320
78459
78464-78465
78469
78491-78492
78494
78607-78609
78647
78710
78803

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 for additional information regarding not covered services or for services that are considered by the Division of Medical Assistance Programs (DMAP) to be bundled.

(2) The following are examples of not covered services:

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

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

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

Table 130-0220-1

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Table 130-0220-1 Not Covered/Bundled Services

Refer to the HSC List for additional not covered services.

BND = bundled services that are included in the base service

For numbers followed by (*#), see additional information below.

00802	89250-	97010 BND	B4034-
19316	89261	97016	B4036
32850 BND	89264	97018	B4100-
33930 BND	89268	97024	B9999
33940 BND	89272	97026	E Codes (*5)
44132 BND	89280-	97028	G0166
44133	89281	97033	G0219
44136	89290-	97034	G0235
47133BND	89291	90735	G0252
48550 BND	89300	97039	G0370
58740 BND	89310	97139	J7319
74740	89320-	97537	K0000-
74742	89321	97802-	K9999
77422	89325	97804	L1844
77423	89329-	99000-	L2750
78459	89330	99002 BND	L2780
78491	89335	99024	L3251
78492	89342-	99026	L5610
78990 (*1)	89344	99027	L5613-
79900 (*1)	89346	99056	L5614
80414-	89352-	99070 (*1)	L5722
80415	89354	99071 BND	L5724
82757	89356	99075	L5726
84030	92354	99100 BND	L5728
84830	92355	99116 BND	L5780-
86891 BND	92508	99135 BND	L5822
86910-	92559	99140 BND	L5824
86911	92592	99360 (*3)	L5828
88000-	92593	A4570 (*4)	L5830
88099	92595 (*2)	A4580 (*4)	L5848
89235	96150-	A4590 (*4)	L5980
89240	96155	A4641	L5989

L6025
L6310
L6360
L6638
L6646
L6648
L6825
L6875
L6881-
L6882
L6920
L6925
L6930
L6935
L6940
L6945
L6950
L6955
L6960
L6965
L6970
L6975
L7010
L7015
L7020
L7025
L7030
L7035
L7040
L7045
L7170
L7180
L7185-
L7186
L7190-
L7191
L7260-
L7261
L7266
L7272
L7274
L7360
L7362
L7364
L7366-
L7368
L7500
L7520
L7900
L8001-
L8002
L8010
L8035
L8039
L8500-
L8501
L8505
L8507
L8510-
L8514
L8600
L8603
L8606
L8610
L8612-
L8614
L8619
L8630-
L8631
L8641-
L8642
L8658-
L8659
L8670
L8699
L9900
M0075
M0076
M0100
M0300-
M0301
P2028-
P2029
P2031
P2033
P2038
P7001
P9010-
P9012
P9016-
P9023
P9031-
P9048
P9050-
P9060
Q0035
Q0091 BND
Q0092 BND
Q0114-
Q0115
Q9952 BND

(*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 DME Table 130-0700-1

7-1-07

410-130-0225 Teaching Physicians

(1) Supervising faculty physicians in a teaching hospital may not bill the Division of Medical Assistance Programs (DMAP) 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 DMAP cost report.

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

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1-1-07

410-130-0230 Administrative Medical Examinations and Reports

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

(2) These services are covered only when requested by an CAF, SPD OMHAS, OYA, SCF branch office or approved by the Division of Medical Assistance Programs (DMAP). 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.]

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410-130-0240 Medical Services

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

(2) Acupuncture may be performed by a physician, a physician's employee-acupuncturist under the physician's supervision, or a licensed acupuncturist, and billed using CPT 97810-97814.

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

(4) Maternity Care and Delivery:

(a) Use Evaluation and Management 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. 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 OB 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 (DMAP) 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 polysomnographs and multiple sleep latency test (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.

Statutory Authority: ORS Chapter 409

Statutes Implemented: 414.065

1-1-07

410-130-0245 EPSDT Program

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

(2) Screening Exams:

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

(b) Periodic EPSDT screening exams must include:

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

(B) Assessment of nutritional status;

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

(D) Appropriate immunizations;

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

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

(G) Health education including anticipatory guidance;

(H) Appropriate hearing and vision screening.

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

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

(3) Referrals:

(a) If, during the screening process (periodic or inter-periodic), a medical, mental health, substance abuse, or dental condition is discovered, the client may be referred to medical providers,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 9033) and/or blood lead tests as indicated.

(5) Lead Risk Assessment Questionnaire: Complete the Lead Risk Assessment Questionnaire (DMAP 9033) found in the Medical-Surgical Services Supplemental Information . The questionnaire must

be used at each EPSDT exam beginning at one year of age to assess the potential for lead exposure. Retain this questionnaire in the client's medical record. Do not attach this form to the claim for reimbursement. DMAP 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 >[] 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 of this rule.

(7) 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.

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

Table 130-0245-1

Table 130-0245-2

Table 130-0245-3

Table 130-0245-4

Table 130-0245-5

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 130-0245-1 Schedule For Confirmatory Testing

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

Screening test (µg/dL) result is:	Perform confirmatory test on venous blood within:
10-14	3 months
15-19	1 month
20-44	1 month - 1 week*
45-59	48 hours
60-69	24 hours
≥70	Immediately as an emergency lab test

*The higher the screening BLL, the more urgent the need for 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 a confirmatory 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 (DMAP) 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. DMAP will not reimburse the cost of privately purchased vaccines that are provided through the VFC Program, but will reimburse for the administration of those 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;

(c) DMAP 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 DMAP;

(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) 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 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 409

Stats. Implemented: ORS 414.065

7-1-07

Table 130-0255-1 Vaccines for Children

90632 (*1)	90702
90633	90707
90636 (*1)	90710
90645	90713
90647	90714
90648	90715
90649	90716
90655 (*2)	90721 (*4)
90656 (*3)	90723
90657 (*2)	90732
90658 (*3)	90733
90660 (*5)	90734
90680	90744
90669	90746 (*1)
90700	90748

(*1) Age 18 only.

(*2) All children ages 6-35 months.

(*3) All children ages 36-59 months and all medically high-risk children ages 60 months through 18 years as defined by the Public Health Immunization Program, including contacts to high-risk household members.

(*4) Use when 90700 and 90648 are given combined in one injection.

(*5) All children ages 5 through 18 who are contacts to high-risk household members, as defined by the Public Health Immunization Program.

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

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

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

(3) Global Rates include:

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

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

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

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

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

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

(g) Blood, blood plasma, platelets;

(h) Materials for anesthesia;

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

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

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

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

(c) Prosthetic devices;

(d) Ambulance services;

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

(f) Artificial legs, arms, and eyes;

(g) Services furnished by a certified independent laboratory.

(5) ASCs and BCs will not be reimbursed for services that are normally provided in an office setting unless the practitioner has justified the medical appropriateness of using an ASC or BC through documentation submitted with the claim. Practitioner's justification is subject to review by the Division of Medical Assistance Programs (DMAP). 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 DMAP.

(6) Procedure Coding:

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

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

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. (DMAP 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.) DMAP 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. DMAP 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 409

Statutes Implemented: 414.065

7-1-07

410-130-0380 Surgery Guidelines

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

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

(3) Global payment for major surgery includes:

(a) Surgery;

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

(c) Initial admission history and physical;

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

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

(f) Hospital discharge.

(4) Global payment for minor surgery includes:

(a) Surgery;

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

(c) Initial admission history and physical;

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

(e) Hospital discharge.

(5) Global payment for endoscopy includes:

(a) Surgery;

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

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

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

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

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

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

(b) Payment will be determined by medical review.

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

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

(b) Payment will be determined by medical review.

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

(a) Primary Procedure paid at 100% of the DMAP maximum fee for that procedure;

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

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

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

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

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

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

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

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

(a) The assistance must be medically appropriate;

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

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

(d) Use an appropriate modifier to indicate assistance.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-130-0562 Abortion

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

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

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

(4) .For services related to surgical abortion such as lab, ultrasound and pathology bill separately. Add modifier U4 (a Division of Medical Assistance Programs (DMAP) modifier) for surgical abortion related services.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

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 DMAP 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 date of the sterilization. If an interpreter is provided to assist the individual being sterilized, the interpreter must also sign the consent form on the same date as the client;

(C) The 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 DMAP 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 409

Stats. Implemented: ORS 414.065

12-20-07 (T)

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 (DMAP) 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 DMAP, 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 DMAP. If the provider is:

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

(b) An enrolled DMAP provider, but is not a participating provider with the client's PHP, bill DMAP and mark the family planning box (24H) with a "Y" on the CMS-1500 claim form or 837P.

(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 (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). 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).

(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 409

Stats. Implemented: ORS 414.065

1-1-07

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 (DMAP) as a Family Planning Clinic, a provider must also be enrolled with the Office of Family Health as a Family Planning Expansion Project (FPEP) provider.

(3) Family Planning Clinics must follow all applicable FPEP and DMAP rules.

(4) DMAP 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 for services provided to clients enrolled in a Prepaid Health Plan, mark the family planning Box 24 H on the CMS-1500 billing form or 837P.

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1-1-07

410-130-0595 Maternity Case Management (MCM)

(1) The primary purpose of the 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, unless specifically indicated in this rule, throughout the client's pregnancy.

(2) This program:

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

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

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

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

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

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

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

(5) Definitions:

(a) Case Management -- An ongoing process to assist the individual client in obtaining access to and effective utilization of necessary health, social, economic, nutritional, and other services as defined in the Client Service Plan (CSP) or other documentation;

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

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

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

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

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

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

(h) Nutritional Counseling -- Intensive nutritional counseling for clients who have at least one of the conditions listed under Nutritional Counseling (14);

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

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

(6) Maternity Case Manager Qualifications:

(a) Maternity case managers must be 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 an enrolled provider or deliver services under an appropriate enrolled provider. See DMAP General Rules 410-120-1260 for provider enrollment qualifications.

(c) All of the above must have a minimum of two years 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 in (6)(a)(A-G) of this rule;

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

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

(a) Be a registered dietician; or

(b) A Qualified Nutritionist. A qualified nutritionist is a nutrition profession who meets one or more of the following qualifications: a Masters Degree in nutrition; a Registered Dietician (RD) with the American Dietetic Association (ADA) or eligible for ADA registration; an Oregon Licensed Dietitian (LD).

(8) Documentation Requirements:

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

(b) A correctly completed DMAP form 2470, 2471, 2472 and 2473 or their equivalents meet minimum documentation requirements for Maternity Case Management Services.

(9) G9001 -- Initial Assessment must be performed by a licensed Maternity Case Manager as defined under (6) (a): above

(a) Services include:

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

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

(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 other relevant information to the prenatal care provider;

(E) Communicating pertinent information to 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) Billable once per pregnancy per provider. No other MCM service can be performed until after an initial assessment has been completed. No other maternity management codes except a Home/Environmental Assessment (G9006) and a Case Management Visit (G9012) may be billed the same day as an initial assessment.

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

(a) Face-to-face client contacts;

(b) Implementation and monitoring of a CSP:

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

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

(c) Referral to services included in the CSP:

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

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

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

(e) 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, 2000). Routinely:

(A) Ask all MCM 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;

(g) Provide linkage to labor and delivery services;

(h) Provide linkage to family planning services as needed;

(i) CSP coordination as follows:

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

(B) Contact with prenatal care provider;

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

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

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

(l) Billable once per pregnancy.

(m) 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.

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

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

(b) Provided case management services to the client for three months or less.

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

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

(b) Provided at least eight Case Management Visits;

(c) Provided high risk case management services to the client for more than three months;

(d) Billable after the delivery and only once per pregnancy;

(e) Can be billed in addition to G9002.

(13) 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) Provided less than eight Case Management Visits;

(c) Provided high risk case management services to the client for three months or less;

(d) Billable after the delivery and once per pregnancy;

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

(14) S9470 -- Nutritional Counseling:

(a) 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 WIC guidelines;

(E) Eating disorder;

(F) Gestational diabetes;

(G) Hyperemesis;

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

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

(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) Billable once per pregnancy.

(15) G9006 -- Home/Environment Assessment:

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

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

(16) G9011 -- Telephone Case Management Visit:

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

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

(17) G9012 -- Case Management Visit:

(a) Each Case Management Visit must include an evaluation and/or revision of objectives and activities addressed in the CSP and at least two training and education topics listed in Table 130-0595-2;

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

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

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

Table 130-0595-1

Table 130-0595-2

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7-1-07

Table 130-0595-1 Environmental Assessment

General Assessment
General Condition of House
Adequacy of Shelter
Food Storage Facilities
Food Preparation Facilities
Health Adequacy: Safety and sanitation
Heating/Cooling/Ventilation
Number of bedrooms vs. number of persons
Running Water
Phone Service
Sanitation/Sewer
Environmental Hazards
Toxins/Teratogens
Safety
Guns: Locked and Unloaded
Smoke Alarm: Installed & Working
Fire Prevention: i.e., smoking habits, if applicable
Adequate Exits: All locations & free of obstacles
Toxins
Lead Exposure: Peeling paint, lead pipes & lead dust
Chemical Use: In or near home
Asbestos
Pets
Cats (Toxoplasmosis)
Birds (Psittacosis)
Reptiles (Salmonella), i.e., iguanas, turtles, snakes

Table 130-0595-2 MCM Training and Education Topics

Mandatory Topics:
Maternal/Fetal HIV Transmission
Fetal Alcohol Syndrome
Prevention of Early Childhood Caries
Maternal Oral Health
Tobacco Use/Exposure-use of “5 A’s”
Lead Exposure and Screening
Immunizations

Other Topics:

Pre-term Birth Prevention
Factors associated with increased risk
Early detection of symptoms
Obtaining help-information
Stress reduction

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

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

Environment
Health Adequacy
Safety and Sanitation
Environmental Hazards

Toxins/Teratogens
Mercury consumption from eating fish
Fluoridated Water Area

Emotional
Stress reduction
Coping strategies
Hormonal changes
Relationships
Maternal/Postpartum Depression

Other
Family planning
Sexually Transmitted Diseases
Substance/alcohol use
Infant Care/Parenting
Feeding/nutrition/infant growth
Clothing needs
Infant sleep patterns and location
Wellness care/immunizations
Breastfeeding
SIDS and BackTo Sleep
Developmental milestones
Common interventions
Individual and Family Emergency Preparedness
Safety
Infant/parent interaction
Bonding/attachment
Infant communication patterns/cues
Parental frustration/sleep deprivation
Household management support
Community resources
Child nurturing/protection

410-130-0610 Telemedicine

(1) For the purposes of this rule, telemedicine is the real time exchange of information for diagnosing and treating medical conditions. The telemedicine technology is an audio/video connection linking a medical practitioner in one locality with a client in another locality.

(2) Coverage for telemedicine:

(a) Telemedicine is covered only for synchronous (live two-way interactive) video transmission which permits real time communications between a medical practitioner located in a distant site and the client being evaluated and located in the originating site;

(b) The 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 (DMAP) provider.

(3) 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.

(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.

(4) Services not covered:

(a) Asynchronous (store and forward later) telecommunications;

(b) Other forms of telecommunications, such as telephone calls, images transmitted via facsimile machines and electronic mail.

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

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410-130-0670 Death With Dignity

(1) All Death with Dignity services must be billed directly to the Division of Medical Assistance Programs (DMAP), 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) DMAP 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 DMAP 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) DMAP 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.

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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) Require prior notification (PN) – OAR 140-130-0200 Table 130-0200-2 (MRIs, MRAs, CTs, CTAs, and SPECT scans require PN and are included in the table), and;

(c) 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 shall be reimbursed only to the OSPHL.

(3) The Division of Medical Assistance Programs (DMAP) covers lab tests performed in relation to a transplant only if the transplant is covered and if the transplant has been authorized. See the DMAP 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) DMAP 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) DMAP 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 DMAP.

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

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

(a) DMAP 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 DMAP 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) DMAP 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) DMAP 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) DMAP 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) DMAP 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.

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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 (DMAP) 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.

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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