Oregon
John A. Kitzhaber, M.D., Governor

Department of Human Services
Health Services
Office of Medical Assistance Programs
500 Summer Street NE, E35
Salem, OR 97301-1077
Voice - (503) 945-5772
FAX - (503) 373-7689
TTY - (503) 378-6791

December 26, 2002

To: Providers of Oregon Health Plan (OHP) Services

From: Joan M. Kapowich, Manager
Program and Policy Section, OMAP

Joan M. Kapowich

Subject: *Oregon Health Plan Administrative Rules* guide, Revision #1

Effective Date: Effective January 1, 2003

The Office of Medical Assistance Programs (OMAP) is revising the *OHP Administrative Rules* provider guide, effective January 1, 2003. **Until the guide revision is posted to the website, please reference the attached Administrative rules and note the following summary of changes:

Summary of changes:

- Rules 410-141-0480, 410-141-0500 and 410-141-0520 pertain to the Prioritized List of Health Services (Prioritized List). Rule 410-141-0520 is amended to "reference" the most current Prioritized List and indicate where the list can be located. The Prioritized List is now a stand-alone document and will no longer be considered a Table in OAR 410-141-0520 nor part of the OHP Provider Guide.

  All three rules are revised to indicate a change to the number of lines covered for payment by OMAP. Due to OMAP Management action to balance the budget shortfall, OMAP will fund and cover for payment only the first 558 lines of the Prioritized List of Health Services, effective January 1, 2003. This decision was contingent upon approval from Centers for Medicare and Medicaid Services (CMS). Other minor housekeeping changes are corrected as needed.

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

Additional information for providers is available at OMAP's website:
www.omap.hr.state.or.us/providerinfo

Oregon Health Plan Benefit Package of Covered Services

410-141-0480 (1) Oregon Health Plan (OHP) Clients are eligible to receive, subject to Section (12) of this rule, those treatments for the condition/treatment pairs appearing on the currently funded lines 1 through [~~566~~]**558** of the **Oregon Health Services Commission's** Prioritized List of Health Services adopted under OAR 410-141-0520 when such treatments are Medically or Dentally Appropriate, except that services must also meet the prudent layperson standard defined in OAR 410-141-0140.

(2) Diagnostic services that are necessary and reasonable to diagnose the presenting condition of the Oregon Health Plan Client are covered services, regardless of the placement of the condition on the Prioritized List of Health Services.

(3) Comfort care is a covered service for an Oregon Health Plan Client with a Terminal Illness.

(4) Preventive Services promoting health and/or reducing the risk of disease or illness are covered services for Oregon Health Plan Clients. Such services include, but are not limited to, periodic medical and dental exams based on age, sex and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors, (See [~~OAR 410-141-0520,~~] Prioritized List of Health Services**, adopted in OAR 410-141-0520**).

(5) Ancillary Services are covered, subject to the service limitations of the Medical Assistance Program rules and provider guides, when the services are Medically or Dentally Appropriate for the treatment of a covered condition-treatment pair, or the provision of ancillary services will enable the Oregon Health Plan Client to retain or attain the capability for independence or self-care. A list of Ancillary Services is included in the Prioritized List of Health Services, **adopted in** OAR 410-141-0520.

(6) The provision of Chemical Dependency Services must be in compliance with the [~~Office of Alcohol and Drug Abuse Programs~~]**Office of Mental Health and Addiction Services (OMHAS)** Administrative Rules, OAR 415-020-0000 to 0090 and 415-051-0000 to 0130 and the Chemical Dependency Prepaid Health Plan Standards in the Fully Capitated Health Plan [~~Agreement~~]**Contract**.

(7) In addition to the coverage available under section (1) of this rule, an Oregon Health Plan Client may be eligible to receive, subject to section (12) services for treatments which are below the funded line or not otherwise excluded from coverage:

(a) Services can be provided if it can be shown that:

(A) The patient has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and

(B) Concurrently has a medically related unfunded condition that is causing or exacerbating the funded condition; and

(C) Treating the unfunded medically related condition will significantly improve the outcome of treating the funded condition;

(D) Ancillary services that are excluded and other services that are excluded are not subject to consideration under this rule;

(E) Any unfunded or funded comorbid conditions or disabilities must be represented by an ICD-9-CM diagnosis code or when the condition is a mental disorder, represented by DSM-IV diagnosis coding to the highest level of axis specificity; and

(F) In order for the treatment to be covered, there must be a medical determination and finding by OMAP for fee-for-service clients or a finding by the managed care plan for enrolled clients that the terms of section (a)[~~(1-3)~~] **A-C** of this rule have been met based upon the applicable:

(i) Treating physician opinion;

(ii) Medical research;

(iii) Community standards; and

(iv) Current peer review.

(b) Before denying treatment for an unfunded condition for any individual, especially an individual with a disability or with a co-morbid condition, providers must determine whether the individual has a funded condition and paired treatment that would entitle the individual to treatment under the program and both the funded and unfunded conditions must be represented by an ICD-9-CM diagnosis code; or, when the condition is a mental disorder, represented by DSM-IV diagnosis coding to the highest level of axis specificity.

(8) OMAP shall maintain a telephone information line for the purpose of providing assistance to practitioners in determining coverage under the Oregon Health Plan Benefit Package of Covered Services. The telephone information line shall be staffed by registered nurses who shall be available during regular business hours. If an emergency need arises outside of regular business hours, OMAP shall make a retrospective determination under this subsection, provided OMAP is notified of the emergency situation during the next business day. If OMAP denies a requested service, OMAP shall provide written notification and a notice of the right to an Administrative Hearing to both the OHP Client and the treating physician within five working days of making the decision.

(9) PHPs shall provide written notification of PHP determinations related to

sections (1) - (7)(a) and (b) of this rule when such determinations result in a denial of requested services or denial of payment for services which have been obtained: If, as the result of a complaint or request for administrative hearing, OMAP determines a service is covered and the Oregon Health Plan Client is enrolled in a PHP that is required to provide the service as a Capitated Service, OMAP shall, within five working days of making a decision, provide written notification to the PHP.

(10) Oregon Health Plan Clients or practitioners, on behalf of Oregon Health Plan Clients, may request an Administrative Hearing to appeal OMAP decisions made related to section (7) of this rule:

(a) Requests for Administrative Hearings may be made orally to the OMAP Medical Director or his or her designee when an Oregon Health Plan Client's condition warrants an expedited decision, OMAP shall respond in a timely manner determined by the nature of the circumstance and in no event greater than ten (10) working days after receiving notice of the oral request for expedited decision;

(b) Requests for Administrative Hearing, appealing OMAP decisions, other than those subject to section (10)(a), must be written. Written appeals may be made through the client Administrative Hearings process or the provider appeals process and shall be responded to within the timelines of those processes in accordance with OAR 410-120-1560 through OAR 410-120-1840.

(11) If a condition/treatment pair is not on the Health Services Commission's list of prioritized services and OMAP determines the condition/treatment pair has not been identified by the Commission for inclusion on the list, OMAP shall make a coverage decision in consultation with the Health Services Commission.

(12) Coverage of services available through the Oregon Health Plan Benefit Package of Covered Services is limited by OAR 410-141-0500, Excluded Services and Limitations for Oregon Health Plan Clients.

(13) General anesthesia for dental procedures which are Medically and/or Dentally Appropriate to be performed in a hospital or ambulatory surgical setting, is to be used only for those clients with concurrent needs: age, physical, medical or mental status, or degree of difficulty of the procedure as outlined below:

(a) Children under three years old with dental needs determined by the dentist or oral surgeon as requiring general anesthesia;

(b) Children over three years old requiring substantial dental care determined by the dentist or oral surgeon as requiring general anesthesia that may protect the child from unnecessary trauma;

(c) Clients with physical, mental or medically compromising conditions;

(d) Clients with dental needs for who local anesthesia is ineffective because of acute

infection, anatomic variations, or allergy;

(e) Acute situational anxiety, fearfulness, extremely uncooperative or uncommunicative client with dental needs, determined by the dentist or oral surgeon, sufficiently important that dental care cannot be deferred;

(f) Clients who have sustained extensive orofacial and dental trauma; or

(g) Clients with dental needs who otherwise would not obtain necessary dental care when, in the decision of the dentist or oral surgeon, the need for dental treatment outweighs the risks of general anesthesia. The client's dental record must clearly document the justification for the level of anesthesia and why, in the estimation of the dentist or oral surgeon, the treatment in an office setting is not possible.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Division 141

410-141-0500

Excluded Services and Limitations for Oregon Health Plan Clients

(1) The following services are excluded:

(a) Any service or item identified in OAR 410-120-1200, Excluded Services and Limitations. Services that are excluded under the Oregon Medical Assistance program shall be excluded under the Oregon Health Plan unless the services are specifically identified in **the Oregon Health Services Commission's** [~~OAR 410-141-0520,~~] Prioritized List of Health Services**, adopted under OAR 410-141-0520**;

(b) Any service or item identified in the appropriate provider guides as a non-covered service, unless the service is identified as specifically covered under the Oregon Health Plan Administrative Rules;

(c) Any treatment, service, or item for a condition that is not listed on the currently funded lines 1 through [~~566~~]**558** of the Prioritized List of Health Services except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (7);

(d) Any treatment, service, or item for a condition which is listed as a Condition/Treatment Pair in both currently funded and non-funded lines where the qualifying description of the diagnosis appears only on the non-funded lines of the Prioritized list of Health Services, except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (7);

(e) Diagnostic services not reasonably necessary to establish a diagnosis for a covered or noncovered condition/Treatment Pair;

(f) Services requested by Oregon Health Plan (OHP) Clients in an emergency care setting which after a screening examination are determined not to meet the definition of Emergency Services and the provisions of 410-141-0140;

(g) Services provided to an Oregon Health Plan Client outside the territorial limits of the United States, except in those instances in which the country operates a Medical Assistance (Title XIX) program;

(h) Services or items, other than inpatient care, provided to an Oregon Health Plan Client who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, per OAR 410-141-0080(2)(b)(G);

(i) Services received while the OMAP Member is outside the Contractor's service area that were either:

(A) Not authorized by the OMAP Member's Primary Care Provider; or

(B) Not urgent or emergency services, subject to the Member's appeal rights, that the OMAP Member was outside Contractor's service area because of circumstances beyond the OMAP Member's control. Factors to be considered include but are not limited to death of a family member outside of

Contractor's service area.

(2) The following services are limited or restricted:

(a) Any service which exceeds those Medically Appropriate to provide reasonable diagnosis and treatment or to enable the Oregon Health Plan Client to attain or retain the capability for independence or self-care. Included would be those services which, upon medical review, provide only minimal benefit in treatment or information to aid in a diagnosis;

(b) Diagnostic Services not reasonably required to diagnose a presenting problem, whether or not the resulting diagnosis and indicated treatment are on the currently funded lines under the Oregon Health Plan Prioritized List of Health Services;

(c) Services that are limited under the Oregon Medical Assistance program as identified in OAR 410-120-1200, Excluded Services and Limitations. Services that are limited under the Oregon Medical Assistance program shall be limited under the Oregon Health Plan unless the services are specifically identified in [~~OAR 410-141-0520,~~]**the Oregon Health Services Commission's** Prioritized List of Health Services**, adopted in OAR 410-141-0520,** or elsewhere in this chapter of the Oregon Administrative Rules.

(3) In the case of non-covered condition/treatment pairs, providers shall ensure that Oregon Health Plan Clients are informed of:

(a) Clinically appropriate treatment that may exist, whether covered or not;

(b) Community resources that may be willing to provide non-covered services;

(c) Future health indicators that would warrant a repeat diagnostic visit.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Prioritized List of Health Services

410-141-0520

(1) [~~The Prioritized List of Health Services is the Health Services Commission listing of physical health services presented to the Oregon Legislative Assembly.~~]**The Prioritized List of Health Services (Prioritized List) is the Oregon Health Services Commission's (HSC) listing of physical health services with "expanded definitions" of Ancillary Services and Preventive Services, as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HSC. The most current list, dated October 1, 2002, is available on the HSC website (http://www.ohppr.state.or.us/). OMAP receives new information or modifications regarding the Prioritized List from HSC in the form of Attachments. The most recent, Attachment A, approved by the HSC July 17, 2002, is available on the HSC website.**

[~~(2) By this reference the Prioritized List of Health Services includes the "expanded definitions" of Ancillary Services and Preventive Services published at the end of the list.~~]

(3) Certain Mental Health services are only covered for payment when provided by a Mental Health Organization (MHO), Community Mental Health Program (CMHP) or authorized Fully Capitated Health Plan (FCHP). These codes are identified on their own Mental Health (MH) section of the appropriate lines on the Prioritized List of Health Services.

(4) Chemical dependency services are covered for all OHP clients when provided by an FCHP or by a provider who has a letter of approval from the Office of Alcohol and Drug Abuse Programs (ODAP) and approval to bill Medicaid for CD services. These codes are identified on the Chemical Dependency (CD) section of line 188.

(5) The first [~~566~~]**558** lines of the Prioritized List of Services are currently funded and are covered for payment by OMAP.

[~~Table 0520-1- (October 1, 2001- Completely Rewritten) updated 10/02/02~~]

[~~Table 0520-2- (October 1, 2001- Completely Rewritten) updated 10/02/02~~]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065