

# **American Indian/Alaska Native (AI/AN) Services Rulebook**

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**DEPARTMENT OF HUMAN SERVICES**  
**MEDICAL ASSISTANCE PROGRAMS**  
**DIVISION 146**  
**AMERICAN INDIAN/ALASKA NATIVE**

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# AI/AN Services Rulebook

## Update Information

February 1, 2007

The Department of Human Services (DHS) changed the name of **Office** of Medical Assistance Programs (**OMAP**) to **Division** of Medical Assistance Programs (**DMAP**). DMAP amended all rules in this Rulebook to reflect this name change, other DHS division name changes and other minor spelling and grammar corrections. Some “non-rule” pages in the Rulebook may have been adjusted for consistency.

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

## Other Provider Resources

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

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### ■ Supplemental Information

The American Indian / Alaska Native Services (AI/AN) Supplemental Information booklet contains important information not found in the rulebook, including:

- ✓ Billing for QMB-only clients
- ✓ Vaccines for Children program information
- ✓ Electronic claims information
- ✓ Prior authorization references
- ✓ Eligibility verification
- ✓ Other helpful information not found in the rulebook

Be sure to download a copy of the AI/AN Services Supplemental Information booklet at:

<http://www.dhs.state.or.us/policy/healthplan/guides/aian/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](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](http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml)

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## **410-146-0000 Foreword**

(1) The Division of Medical Assistance Programs (DMAP) American Indian/Alaska Native (AI/AN) billing rules are designed to assist AI/AN Tribal Clinics/Health Centers, Indian Health Services (IHS), Federally Qualified Health Clinics (FQHC) with a 638 designation including, Urban Clinics, that are enrolled as AI/AN providers, to deliver health care 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) AI/AN clients can choose to be exempt from managed care organizations (see OAR 410-141-0060) and receive their care from AI/AN Health Care Facilities, or any other private provider enrolled with DMAP.

(3) AI/AN clients can choose to enroll in a managed care organization and continue to receive care on an infrequent basis from AI/AN Health Care Facilities. If the client chooses to remain in a managed care organization they must follow all managed care rules when seeking services outside of AI/AN Health Care Facilities. When a client chooses to utilize services through a managed care organization they must contact their plan for coverage and prior authorization information.

(4) These rules contain information on policy, special programs services outside of the encounter rate, such as, pharmacy, lab, x-ray, and Durable Medical Equipment (DME), etc., and criteria for some services. All DMAP rules are used in conjunction with the DMAP General Rules and the Oregon Health Plan Administrative Rules.

(5) AI/AN Health Care Facilities that have a pharmacy will need the DMAP Pharmacy rules. AI/AN pharmacies that provide DME and Medical Supplies will also need the DMEPOS rules.

(6) The Health Services Commission's Prioritized List of Health Services (see OAR 410-141-0520), defines the covered services under DMAP.

(7) Note: Urban Tribal Clinics are not recognized under the Centers for Medicare and Medicaid Services (CMS) 1996 Memorandum of Agreement (MOA).

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0020 Memorandum of Agreement (MOA)**

(1) The State of Oregon, Division of Medical Assistance Programs (DMAP) recognizes the Centers for Medicare and Medicaid Services (CMS) Memorandum of Agreement (MOA).

(2) MOA outlines payment methodologies available to Tribal Facilities. Refer to 410-146-0420 for specific details.

(3) Urban Tribal Clinics are not recognized under CMS's MOA.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0021 American Indian/Alaska Native (AI/AN) Provider Enrollment**

(1) Any of the following facilities may enroll as an AI/AN clinic provider:

(a) Indian Health Services (IHS) Health facility;

(b) Federally recognized Indian tribe, tribal organization; or

(c) Federally Qualified Health Clinic (FQHC) with a 638 designation excluding Urban Tribal Clinics.

(2) AI/AN Urban Health Care Facilities refer to OAR 410-146-0400 for enrollment information.

(3) If an IHS or other federally recognized Indian tribe or tribal organization applies to enroll as an AI/AN provider, that clinic must show proof of federal recognition.

(4) If an IHS or other federally recognized Indian tribe or tribal organization has a pharmacy or supplies durable medical equipment (DME) and medical supplies, that clinic must apply for a pharmacy provider number and/or apply for a DME provider number in addition to the clinic provider number.

(5) If an IHS or other federally recognized Indian tribe or tribal organization provides van/sedan transportation the clinic does not apply for a transportation provider number. Their AI/AN clinic number is used as outlined in OAR 410-146-0240.

(6) Urban Tribal Healthcare Facilities with 638 designations may enroll as an Urban Tribal Facility.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0022 OHP Standard Benefit for AI/AN Clients**

(1) OHP Standard Benefit for AI/AN Clients

(2) Once the Division of Medical Assistance Programs (DMAP) receives authorization to implement SB 878 from the Centers for Medicare and Medicaid Services, OHP Standard AI/AN clients have the following benefits:

(a) AI/AN Clients eligible for the OHP Standard Benefit are allowed by the authority of SB 878 to receive all services allowed under the OHP Plus Benefit that are reimbursed by CMS at 100% FPL;

(b) AI/AN Clients eligible for the OHP Standard Benefit do not change eligibility group unless allowed by OAR. For example OHP Standard female client becomes pregnant and moves into OHP Plus during pregnancy;

(c) Excluded Services: Transportation.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0025 Reimbursement for AI/AN Health Care Facilities**

(1) Services provided by facilities of the Indian Health Service (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organizations, and funded by Title I or IV of the Indian Self Determination and Education Assistance Act (Public Law 93-638), may select the reimbursement methodology as outlined in 410-146-0420.

(2) AI/AN Health Care Facilities that qualify under the Memorandum of Agreement may choose one of the following payment methodologies:

(a) Paid at the rates negotiated between the Centers for Medicare and Medicaid Services (CMS) and IHS, which are published in the Federal Register or Federal Register Notices annually. This methodology is referred to as the Tribal encounter rate;

(b) Tribal Health Care Facility excluding AI/AN Urban Health Care Facilities, with a Title I or V designation serving as an Indian Tribal Health Center may be reimbursed using 100% reasonable costs paid on a per encounter basis; or

(c) Reimbursed on a per service basis. This is also known as fee-for-service.

(3) If a Tribal Health Care Facility chooses the 100% reasonable costs encounter rate, they are not eligible for Administrative Match contracts.

(4) AI/AN Urban Tribal Health Care Facilities are not eligible for Administrative Match contracts.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0040 ICD-9-CM Diagnosis Codes**

(1) The appropriate code or codes from 001.0 through V82.9 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reasons for the encounter/visit. Diagnosis codes are required on all claims, including those submitted by independent laboratories and portable radiology including nuclear medicine and diagnostic ultrasound providers. Always provide the client's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(2) The principal diagnosis is listed in the first position; the principal diagnosis is the code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Up to three additional diagnosis codes may be listed on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect client care, treatment, or management.

(3) The diagnosis codes must be listed using the highest degree of specificity available in the ICD-9-CM. A three-digit code is used only if it is not further subdivided. Whenever fourth-digit subcategories and/or fifth-digit subcategories are provided, they must be assigned. A code is invalid if it has not been coded to its highest specificity.

(4) The Division of Medical Assistance Programs (DMAP) requires accurate coding and applies the national standards in effect for calendar years 2004 and 2005 set by the American Hospital Association, American Medical Association, and Centers for Medicare and Medicaid Services (CMS). DMAP has unique coding and claim submission requirements for Administrative Exams; specific diagnosis coding instructions are provided in the Administrative Examination and Report Billing provider rules.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0060 Prior Authorization**

(1) No prior authorization (PA) is required for services provided within an American Indian/Alaska Native (AI/AN) Health Care Facility with the sole exception of pharmacy, DME and Hospital Dentistry services. Refer to the Pharmacy and DME program rules for more detailed information.

(2) If a client is enrolled in a managed care plan there may be PA requirements for some services that are provided through the managed care plan. Contact the client's managed care plan for specifics.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0075 Client Copayments**

(1) American Indian/Alaska Native (AI/AN) are not required to pay copayments for services provided through Indian Health Services (IHS), a Federally recognized Indian Tribe or Tribal Organization. This includes any health care services provided to the AI/AN member and is defined as provided directly, by referral, or under contracts or other arrangements between IHS, a Federally recognized Indian Tribe, Tribal Organization or an Urban Tribal Health Clinic and another health care provider.

(2) AI/AN are not required to pay copayments for services provided at an Urban Tribal Health Clinic.

(3) AI/AN Tribal Health Facilities may not charge copayments to non-AI/AN Medical Assistance Program clients receiving care at the Tribal Health Facility.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0080 Professional Services**

(1) Medical, Diagnostic, Screening, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Drug, Maternity Case Management, Speech, Hearing, or, Home Health services are not limited except as directed by the General Rules - Medical Assistance Benefits: Excluded Services and Limitations and the Health Services Commission's (HSC) Prioritized List of Health Services (List) as follows:

(a) Coverage for diagnostic services and treatment for those services funded on the HSC List, and;

(b) Coverage for diagnostic services only, for those conditions that fall below the funded portion of the HSC List;

(c) The date of service determines the appropriate version of the General Rules and the HSC List to determine coverage;

(d) The OHP Standard Benefit Package is a limited benefit package. See OAR 410-120-1210 for details.

(2) American Indian/Alaska Native (AI/AN) Health Care Facilities are eligible under the Memorandum of Agreement (MOA) for reimbursement at the Tribal encounter rate for professional services.

(3) Urban clinics are not eligible, under the MOA, for reimbursement but are eligible to bill for all professional services as outlined in this rule.

(4) AI/AN Health Care Facilities, that have chosen to be reimbursed using the per service payments also known as fee-for-service, do not use the per encounter definitions. However, all services listed in (1) of this rule apply.

(5) Encounter:

(a) An encounter is defined as "A face-to-face contact between a health care professional and an Indian Health Services (IHS) beneficiary eligible for the Medical Assistance Program for the provision of Title XIX/CHIP defined services in an AI/AN Health Care Facility within a 24-hour period ending at midnight, as documented in the client's medical record";

(b) An encounter can occur either within or through the AI/AN Health Care Facility;

(6) The following encounters are reimbursable under the MOA encounter rate, 100% cost based reimbursement or an Urban Tribal Clinic eligible to bill as a Federally Qualified Health Center with or without a 638 designation:

(a) Physicians;

(b) Licensed Physician Assistants;

(c) Nurse Practitioners;

(d) Nurse Midwives;

(e) Dentists;

(f) Pharm D; or

(g) other health care professionals:

(A) To provide: Medical, Diagnostic, Screening, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Drug, Maternity Case Management, Speech, Hearing, or Home Health Services;

(B) Professional services provided in a hospital setting;

(C) Services outside of the encounter rate include but not limited to Pharmacy, DME, Lab, Radiology, Targeted Case Management, Administrative Examinations, and Medical Transportation. These services are reimbursed under the Division of Medical Assistance Programs (DMAP) fee-for service system;

(D) Effective March 1, 2003, the OHP Standard Benefit has limited services. See OAR 410-120-1235 for detailed list of non-covered services.

(7) Multiple Encounters: Each service must be a distinctly different service in order to meet the criteria for multiple encounters. For example: a medical visit and a dental visit on the same day is considered two distinctly different services.

(8) Similar services, even when provided by two different health care practitioners are not considered multiple encounters. Situations that would not be considered multiple encounters provided on the same date of service include, but are not limited to:

(a) A well child check and an immunization;

(b) A well child check and fluoride varnish application in a medical setting;

(c) A medical encounter with a mental health or addiction diagnosis on the same day as a mental health or addiction encounter;

(d) A mental health and addiction encounter;

(e) Any time a client receives only a partial service with one provider and partial service from another provider it is considered a single encounter.

(9) Medical encounter definitions:

(a) More than one outpatient visit, with a medical professional, within a 24-hour period, for the same diagnosis, constitutes a single encounter. For example: a client comes to the clinic in the morning for an examination. During the examination the client is diagnosed with hypertension. The practitioner prescribes medication and asks the client to return in the afternoon for a blood pressure check;

(b) More than one outpatient visit, with a medical professional, within a 24-hour period, for distinctly different diagnoses, report as two encounters. For example, a client comes to the clinic in the morning for an immunization and in the afternoon falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two encounters. However, a client that comes to the clinic for a prenatal visit in the morning and delivers in the afternoon would not be considered a distinctly different diagnosis and can only be billed as a single encounter;

(c) This does not imply that if a client is seen at a single office visit with multiple problems, that multiple encounters can be billed.

(10) The following services may be considered as multiple encounters when two or more services are provided on the same date of service:

(a) Dental;

(b) Mental Health or Addiction Services - If both services are provided on the same date of service, then it's considered a single encounter. In addition, if the client is also seen for a medical office visit with a mental health or addiction diagnosis, it is considered a single encounter;

(c) Ophthalmologic services - fitting and dispensing of eyeglasses is included in the encounter that the vision exam is performed;

(d) Maternity Case Management (MCM) - When a client has a medical office visit, MCM can only be billed as a multiple encounter when the client is newly diagnosed as pregnant and is referred for MCM assessment or it is determined the client needs nutritional counseling;

(e) Physical or Occupational Therapy (PT/OT) - If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT, then it would only constitute a single encounter;

(f) Immunizations - if no other medical office visit occurs on the same date of service;

(g) Tobacco cessation if no other medical or addition encounter occurs on the same date of service.

(11) The billing guidelines provided in the AI/AN billing rules for those clinics reimbursed using a per encounter rate methodology are limited to specific CPT/HCPCS codes when reporting an encounter that may not be consistent with national coding standards. This does not apply to ICD-9-CM diagnosis coding. Bill DMAP with the procedure codes indicated in each service category for services included in the AI/AN encounter rate. For services that are not included in the encounter rate or under the MOA

please refer to the Services Not Eligible Under the MOA section of the AI/AN billing rules for billing instructions.

(12) When billing for a clinic visit, select the most appropriate CPT/HCPCS procedure code ranges shown in Table 146-0080-1.

(13) It is the HSC's intent to cover reasonable diagnostic services to determine diagnoses on the HSC List, regardless of their placement on the HSC List.

Table 146-0080-1

Table 146-0080-2

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

**Table 146-0080-1 American Indian/Alaska Native (AI/AN) Tribal Program Encounter Codes & Modifiers - Effective August 1, 2004**

Tribal Health Facilities including Urban Clinics are limited to the procedure codes listed in this Table when billing for services that are included in the Encounter Rate. Codes used as an encounter represent all service provided to a client on the same date of service. The modifiers listed are required when appropriate.

The clinical documentation must support the procedure code reported and meet National Coding Standards.

<p>Routine Medical Office Visits: 99201-99350 99372 or 99381-99440</p>	<p>Immunization Administration: 90471 <b>Only use 90471 if administration of an immunization is the sole purpose of the clinic visit. Use modifier SL or SK as appropriate.</b></p>	<p>Tobacco Cessation: S9075 or G9016 <b>Only use if it is the sole reason for the visit.</b></p>
<p>Maternity Case Management (MCM): G9012 <b>HCPCS G9012 is used for all MCM services</b></p>	<p>Antepartum, Postpartum Visits or Prenatal Care: 99201-99340 99372 or 99381-99440</p>	<p>Delivery Services: 59409 59514 59612 or 59620</p>
<p>Fluoride Varnish: D1203 or D1204 <b>Only use if it is the sole reason for the dental visit. If Fluoride Varnish is provided in a medical office visit D1203 or D1204 may not be reported as an encounter code and is included in</b></p>	<p>Dental Prophylaxis: D1110-D1203 <b>Only use this procedure code if it is the sole reason for the dental visit.</b></p>	<p>Dental Exams: D0120-D0180</p>

<p><b>the medical visit encounter. D1203 or D1204 cannot be billed on the same date of service as another dental procedure.</b></p>		
<p>Ophthalmological Services:  <b>(Excluding exams for the purpose of prescribing glasses or contacts)</b>  92002-92014</p>	<p>Eye Exams:  <b>(Prescription of glasses or contacts)</b>  S0620-S0621  <b>Fitting, dispensing and repair is included in the encounter rate paid at the time of the exam. All glasses or contacts must be purchased through the DMAP Vision Supply Contract.</b></p>	<p>Physical &amp; Occupational Therapy:  97001-97004</p>

## Table 146-0080-2 OHP Plus Dental Services

Codes listed in this table are covered services for OHP Plus. Refer to Table 147-0120-3 for a list of covered Dental services for OHP Standard.

Tribal Health Facilities bill on a CMS 1500 with ICD-9-CM diagnoses when billing for dental services.

Refer to Table 146-0080-1 for a list of procedure codes used to bill Tribal encounter.

D0120	D0474	D2752	D3353
D0140	D0480	D2910	D3950
D0150	D0502	D2920	D4210
D0160	D1110	D2930	D4240
D0170	D1120	D2931	D4241
D0180	D1201	D2932	D4245
D0210	D1203	D2933	D4260
D0220	D1320	D2940	D4261
D0230	D1351	D2950	D4268
D0240	D1510	D2951	D4341
D0250	D1515	D2954	D4342
D0260	D1520	D2955	D4355
D0270	D1525	D2957	D4910
D0272	D1550	D2970	D4920
D0274	D2140	D2980	D5110
D0277	D2150	D3220	D5120
D0290	D2160	D3221	D5130
D0310	D2161	D3230	D5140
D0320	D2330	D3240	D5213
D0321	D2331	D3310	D5214
D0322	D2332	D3320	D5410
D0330	D2335	D3330	D5411
D0340	D2390	D3331	D5421
D0350	D2710	D3332	D5422
D0415	D2721	D3333	D5510
D0472	D2722	D3351	D5520
D0473	D2751	D3352	D5610

D5620	D5934	D7441	D7990
D5630	D5935	D7450	D7997
D5640	D5936	D7451	D8010
D5650	D5937	D7471	D8020
D5660	D5951	D7490	D8030
D5710	D5952	D7510	D8040
D5711	D5953	D7520	D8050
D5720	D5954	D7530	D8060
D5721	D5955	D7540	D8070
D5730	D5958	D7550	D8080
D5731	D5959	D7560	D8090
D5740	D5960	D7610	D8210
D5741	D5983	D7620	D8220
D5750	D5984	D7630	D8660
D5751	D5985	D7640	D8670
D5760	D5986	D7650	D8680
D5761	D5987	D7660	D8690
D5820	D6930	D7670	D8999
D5821	D6972	D7680	D9110
D5850	D6980	D7710	D9211
D5851	D7111	D7720	D9212
D5911	D7140	D7730	D9220
D5912	D7210	D7740	D9221
D5913	D7220	D7750	D9230
D5915	D7230	D7760	D9241
D5916	D7240	D7770	D9242
D5919	D7241	D7780	D9248
D5922	D7250	D7910	D9310
D5923	D7260	D7911	D9420
D5924	D7270	D7912	D9430
D5925	D7285	D7920	D9440
D5926	D7286	D7950	D9610
D5928	D7287	D7970	D9630
D5929	D7320	D7980	D9930
D5931	D7340	D7981	D9999
D5932	D7350	D7982	
D5933	D7440	D7983	

## **410-146-0100 Vaccines for Children (VFC)**

(1) American Indian/Alaska Native (AI/AN) Health Care Facilities are eligible under the Memorandum of Agreement (MOA) for reimbursement for the administration of vaccines. These services are billed on a CMS-1500 or 837P using diagnoses that meet national coding standards and the appropriate encounter code. Refer to Supplemental Information, found on the Division of Medical Assistance Programs (DMAP) website, for billing instructions.

(2) The Vaccines for Children (VFC) Program was implemented by DMAP on April 1, 1996. Under this federal program certain immunizations are free for clients ages 0 through 18. For more information on how to enroll for the VFC Program, call the Oregon Health Division.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0120 Maternity Case Management Services**

(1) American Indian/Alaska Native Health Care Facilities are eligible for reimbursement for Maternity Case Management (MCM) services.

(2) Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) are eligible for reimbursement for Maternity Case Management (MCM) services. These services are billed using HCPCS code G9012 for each MCM encounter.

(3) Clients records must reflect the all MCM services provided including all mandatory topics. Refer to Medical/Surgical OAR 410-130-0595 for specific requirements of the MCM program.

(4) The primary purpose of the MCM program is to optimize pregnancy outcomes including the reduction of low birth weight babies. MCM services are intended to target pregnant women early during the prenatal period and can only be initiated when the client is pregnant and no later than the day prior to delivery. MCM services cannot be initiated the day of delivery, during postpartum or for newborn evaluation. Clients are not eligible for MCM services if the MCM initial evaluation has not been completed prior to the day of delivery.

(5) Multiple MCM encounters in a single day cannot be billed as multiple encounters. A prenatal visit and a MCM service on the same day can be billed as two encounters only if the MCM service is the initial evaluation visit. After the initial evaluation visit, the nutritional counseling MCM service can be billed on the same day as a prenatal visit.

(6) The MCM 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 post-partum period;

(c) Is an additional set of services over and above medical management, including perinatal services of pregnant clients;

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

(7) MCM case managers are required to notify the:

(a) Prenatal care provider when:

(A) MCM services have been initiated; and

(B) Any time there is a significant change in the health, economic, social, or nutritional factors of the client.

(b) Health Division for all first-born babies.

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

(9) Four Case Management Visits may be billed per pregnancy. Six additional Case Management Visits may be billed if the client is identified as High Risk.

(10) DMAP recognizes Community Health Representatives (CHR) may be eligible to provide MCM services under the supervision of licensed health care practitioners as outlined in OAR 410-130-0595, may provide specific services.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0130 Modifiers**

(1) The Division of Medical Assistance Programs (DMAP) uses nationally recognized modifiers for many services. The modifiers listed in the American Indian/Alaska Native (AI/AN) billing rules are required.

(2) Refer to OAR 410-146-0080 Billing Codes Table 146-0080-1 for list of required modifiers.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0140 Tobacco Cessation**

(1) AI/AN Health Care Facilities are eligible under the MOA for reimbursement for tobacco cessation services. These services are billed on a CMS-1500 using diagnosis code 305.1 only and either S9075 or G9016 as appropriate.

(2) Follow criteria outlined in OAR 410-130-0190.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0160 Administrative Medical Examinations and Reports**

(1) Administrative medical examinations and reports are not eligible under the Memorandum of Agreement (MOA). Reimbursement for administrative examinations and reports are through the Division of Medical Assistance Programs (DMAP) fee-for-service program. Do not use the American Indian/Alaska Native (AI/AN) Health Care Facility encounter code or rate for these services.

(2) AI/AN Health Care Facilities can be reimbursed for administrative medical examinations and reports when requested by a DHS branch office, or approved by DMAP. The branch office may request an Administrative Medical Examination/Report Authorization (DMAP 729) to establish client eligibility for an assistance program or casework planning.

(3) Administrative medical examinations are billed on a CMS-1500 using V68.89 as the diagnosis only and the DMAP unique procedure code that represents the exam provided.

(4) See the Administrative Examination and Report Billing guide for more detailed information on procedure codes and descriptions.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0180 Durable Medical Equipment and Medical Supplies**

(1) Durable Medical Equipment (DME) and Medical Supplies are not eligible under the Memorandum of Agreement (MOA).

Reimbursement for DME services are through the Division of Medical Assistance Programs (DMAP) fee-for-service program. Do not use the American Indian/Alaska Native (AI/AN) Health Care Facility encounter code or rate for these services.

(2) If an AI/AN Pharmacy is also supplying DME and Medical Supplies the pharmacy must also enroll as a DMAP DME provider. Follow the guidelines in the DMEPOS guide for billing and prior authorization of these items and services.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0200 Pharmacy**

(1) Pharmacy services are not eligible under the Memorandum of Agreement (MOA). Reimbursement for pharmacy services are through the Division of Medical Assistance Programs (DMAP) fee-for-service program.

(2) Do not use the American Indian/Alaska Native (AI/AN) Health Care Facility encounter code or rate for these services. AI/AN pharmacy providers use the Pharmacy guide for a complete listing of all rules and policies.

(3) Follow criteria outlined in the following:

(a) Not Covered Services -- OAR 410-121-0147;

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

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

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

(e) Clozapine Therapy -- OAR 410-121-0190;

(f) Notation on Prescription -- OAR 410-121-0144.

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Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0220 Death With Dignity**

(1) Death With Dignity is a covered service, except for those facilities limited by the Assisted Suicide Funding Restriction Act of 1997 (ASFRA), and is incorporated in the "comfort care" condition/treatment line on the Health Services Commission's Prioritized List of Health Services.

(2) 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.

(3) Follow criteria outlined in OAR 410-130-0670.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0240 Transportation**

(1) American Indian/Alaska Native (AI/AN) Health Care Facilities can be reimbursed for medically appropriate transportation services provided to clients who are eligible for medical assistance and receive health services through an AI/AN Health Care Facility.

(2) Transportation is outside of the Memorandum of Agreement (MOA) encounter rate and must be billed to the Division of Medical Assistance Programs (DMAP) fee-for-service on a CMS-1500 billing form with a diagnosis code. Enrolled AI/AN Health Care Facilities providing medical transportation will not be enrolled as a transportation provider. When billing for an approved transportation service use the AI/AN Health Care Facility provider number.

(3) Use the HCPCS code listed in the AI/AN billing guide that represents the transportation service provided. Do not use the AI/AN Health Care Facility encounter code or rate but rather the HCPCS or DMAP unique procedure code and rate listed for each service. Non-emergency ambulance, air ambulance, commercial air, bus, or train requires advance arrangement and prior approval through the local Seniors and People with Disabilities Division (SPD) (formerly SDSD) or Children, Adults and Families (CAF) (formerly AFS) branch office.

(4) Reimbursement for transportation is based on the following conditions:

(a) The car/van or wheelchair car/van is owned or leased by the AI/AN Health Care Facility;

(b) The individual providing the service is an employee of the AI/AN Health Care Facility;

(c) The service to be provided is the most cost effective method that meets the medical needs of the client;

(d) The service to be provided at the point of origin and/or destination is a medical service covered under DMAP or the MOA.

(5) The following information must be documented in the client's record or a single ledger that contains all medical transportation services for all clients of the facility:

(a) Trip information including date of service, if one way, round trip, or three-way and if transportation needs are ongoing;

(b) Client information, for example, requires wheelchair, walker, cane, needs assistance, requires portable oxygen, etc.

(6) Use the appropriate HCPCS code listed in the AI/AN billing guide to bill for transportation services.

(7) Tribal facility owned or leased car/van (sedan transport):

(a) When client circumstance requires an escort or attendant or when a second client is transported from the same point of origin to the same destination, no additional charge beyond the actual mileage is allowed;

(b) If more than one client is transported from a single pickup point to different destinations or from different pickup points to the final destination the total mileage may be billed. No duplicated miles traveled may be billed;

(c) A0170 All inclusive rate -- \$1.19 per mile.

(8) Tribal facility owned/leased wheelchair car/van (sedan transport):

(a) If a client is able to transfer from wheelchair to car/van use the car/van all-inclusive service. If two DMAP clients are transported by the same mode (e.g., wheelchair van) at the same time, DMAP will reimburse at the full base rate for the first client and one-half the appropriate base rate for each additional client. If two or more DMAP clients are transported by mixed mode (e.g., wheelchair van and ambulatory) at the same time, DMAP will reimburse at the full base rate for the highest mode for the first client and one-half the base rate of the appropriate mode for each additional client. Reimbursement will not be made for duplicated miles traveled. If more than one client

is transported from a single pickup point to different destinations or from different pickup points to the final destination the total mileage may be billed. The first 10 miles is included in the Base Rate and should be included in the total number of miles on the CMS-1500:

(A) A0130 -- Base Rate: \$17.72;

(B) T2002 -- Mileage (each way): \$1.19 per mile. The first 10 miles are included in the Base Rate. When billing mileage, place the total number of miles in Field 24G and the DMAP system will automatically deduct 10 miles;

(C) T2001 -- Extra Attendant (each): \$17.72.

(b) When billing for transportation use TOS code "D" and the appropriate POS code listed below:

(A) E -- Home to Medical Practitioner;

(B) F -- Home to Hospital;

(C) G -- Home to Nursing Facility;

(D) H -- Home to Other;

(E) J -- Nursing Facility to Medical Practitioner;

(F) K -- Nursing Facility to Hospital;

(G) L -- Nursing Facility to Home;

(H) M -- Nursing Facility to Other;

(I) N -- Hospital to Home;

(J) P -- Hospital to Nursing Facility;

(K) Q -- Hospital to Other Hospital;

(L) R -- Hospital to Other;

(M) S -- Medical Practitioner to Hospital;

(N) T -- Medical Practitioner to Nursing Facility;

(O) U -- Medical Practitioner to Home;

(P) V -- Medical Practitioner to Other;

(Q) W -- Other to Hospital;

(R) X -- Other to Other.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0340 Medicare/Medical Assistance Program Claims**

(1) If a client has both Medicare and Medical Assistance Program coverage, providers must bill Medicare first. Medicare will automatically forward all claims to the Division of Medical Assistance Programs (DMAP) for processing. However, since American Indian/Alaska Native (AI/AN) Health Care Facilities must bill DMAP using the most appropriate code as described in the AI/AN billing guide, some of these claims may not be processed and paid automatically. If your claim cannot be paid and processed automatically, a Remittance Advice instructing you to rebill DMAP on the CMS-1500 claim form will be sent to you.

(2) If an out-of-state Medicare carrier or intermediary was billed, you must bill DMAP using a CMS-1500 claim form, but only after that carrier has made payment determination.

(3) When rebilling on the CMS-1500, bill all services for each encounter under the most appropriate code as directed in the AI/AN billing guide. Enter any Medicare payment received in the "Amount Paid" field or use the appropriate TPR explanation code in Field 9 of the CMS-1500 claim form. See billing instructions for details.

(4) DMAP payment will be based on the allowable cost per encounter, less the actual Medicare payment amount.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0380 OHP Standard Emergency Dental Benefit**

(1) The intent of the OHP Standard Emergency Dental benefit is to provide services requiring immediate treatment and is not intended to restore teeth.

(2) Services are limited to those procedures listed in Table 146-0380-1 and are limited to treatment for conditions such as:

(a) Acute infection;

(b) Acute abscesses;

(c) Severe tooth pain; and

(d) Tooth re-implantation when clinically appropriate.

(3) Hospital Dentistry is not a covered benefit for the OHP Standard population except:

(a) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia; or

(b) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia.

(4) Any limitations or prior authorization requirements on services listed in OAR 410-123-1260 will also apply to services in the OHP Standard benefit.

Table 146-0380-1

Stat. Auth.: ORS 409

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2-1-07

## Table 146-0380-1

OHP Standard Dental Services  
Effective August 1, 2004

- Codes listed in this table are covered services for the OHP Standard Dental Emergency Benefit.
- Tribal Health Facilities bill on a CMS 1500 with ICD-9-CM diagnoses when billing for dental services..
- Refer to Table 146-0080-1 for a list of procedure codes used to bill a Tribal encounters.

D0140	D7510
D0170	D7520
D0220	D7911
D0230	D9110
D0240	D9210
D0250	D9215
D0260	D9230
D0270	D9410
D0272	D9420
D0330	D9440
D2910	
D2920	
D2940	
D3110	
D3220	
D3221	
D6930	
D7111	
D7140	
D7210	
D7220	
D7230	
D7240	
D7241	
D7250	
D7260	
D7270	

## **410-146-0400 American Indian/Alaska Native (AI/AN) Urban Health Care Facility Enrollment**

(1) The Centers for Medicare and Medicaid (CMS) do not recognize AI/AN Urban Health Care Facilities under the Memorandum of Agreement (MOA) agreement and are not eligible to be reimbursed using the Tribal encounter rate.

(2) AI/AN Urban Health Care Facilities that have a Federally Qualified Health Center (FQHC) status are required to submit financial documentation prior to enrollment. The term “required financial documents” in this rule refers to:

(a) Cost Statement (DMAP 3027) or Medicare Cost Report for Rural Health Clinics (RHC);

(b) Cost Statement Worksheet (DMAP 3032);

(c) A copy of the clinic’s trial balance;

(d) Audited financial statements if, the clinic received more than \$250,000 total Medicaid funds in a calendar year;

(e) Depreciation schedules;

(f) Overhead cost allocation schedules; and

(g) Complete copy of the grant proposal detailing the clinic’s service and geographic scope.

(3) FQHC Enrollment:

(a) To be eligible for payment under the Prospective Payment System (PPS) encounter rate methodology, all FQHCs must meet the following criteria:

(A) Centers receiving Public Health Services (PHS) grant funds under authority of Section 330 – Migrant Health Centers, Community Health

Centers, or Services to Homeless Individuals, must submit: a copy of the notice of current grant award, the Division of Medical Assistance Programs (DMAP) Provider Application (DMAP 3117), documents showing the clinic's scope of services, and the required financial documents;

(B) For non-federally funded health centers that PHS recommends, and the Centers for Medicare and Medicaid Services (CMS), determines should be designated as an FQHC (i.e., "Look Alikes"), the clinic must submit: a copy of the letter from CMS designating the facility as a "Look Alike" or designating the facility as a non-federally funded health center, a DMAP Provider Application (DMAP 3117), documents showing the clinic's scope of services, and the required financial documents;

(C) For non-federally funded health centers that CMS determines may, for good cause, qualify through waivers of CMS requirements, the clinic must submit: a copy of the letter from CMS designating the facility as a "Look Alike," a DMAP Provider Application (DMAP 3117), documents showing the clinic's scope of services, and the required financial documents. Waivers may be granted for up to two years;

(D) For outpatient health programs or facilities operated by an American Indian tribe under the Indian Self-Determination Act and for certain facilities serving urban American Indians/Alaska Natives.

(b) The DMAP Provider Application (DMAP 3117) and the required financial documents will be reviewed by DMAP for compliance with program rules prior to enrollment as an FQHC;

(c) Submit completed Cost Statements (DMAP 3027) one each for medical, dental and mental health. Addiction services are included in mental health costs, Cost Statement Worksheets (DMAP 3032), and the required financial documents to DMAP;

(d) If an FQHC provides mental health services the clinic must submit a copy of their certification from the Office of Mental Health and Addiction Services (OMHAS);

(e) If an FQHC provides addiction services, the clinic must submit a copy of their certification from OMHAS;

(f) A list of all MCO contracts;

(g) A list of names of all practitioners working within the FQHC and a list of all individual DMAP provider numbers;

(h) List of all clinics affiliated or owned by the FQHC including any clinics that do not have FQHC or RHC status along with all DMAP provider numbers assigned to these clinics.

(4) If an AI/AN Urban Health Care Facility does not meet these criteria they can enroll with DMAP as an individual clinic for reimbursement on a per service basis, also known as fee-for-service.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0420 Reimbursement Methodology**

(1) AI/AN Tribal Health Care Facilities that qualify under CMS's Memorandum of Agreement may select one of the following reimbursement methodologies:

(a) Tribal encounter rate that is paid at the rates negotiated between the Centers for Medicare and Medicaid Services (CMS) and IHS, which are published in the Federal Register or Federal Register Notices annually:

(A) Note: If the negotiated rates for the IHS encounter is published in the Federal Register after the effective date of the new rate the Division of Medical Assistance Programs (DMAP) will retroactively reimburse the difference for all claims paid to American Indian/Alaska Native (AI/AN) Health Care Facilities with dates of service on or after the effective date of the new rate;

(B) AI/AN Tribal Health Care Facilities that choose the Tribal encounter rate may be eligible for an Administrative Match contract with DMAP;

(C) AI/AN Tribal Health Care Facilities that choose the Tribal encounter rate are eligible to receive managed care supplemental payments if they have contracts with DMAP managed care organizations.

(b) 100% of reasonable costs:

(A) An encounter rate that is calculated on indirect and direct clinic costs for Medicaid services;

(B) AI/AN Tribal Health Care Facilities that choose the 100% of reasonable costs are not eligible for an Administrative Match contract with DMAP. These costs are included in the indirect and direct costs;

(C) AI/AN Tribal Health Care Facilities that choose the 100% of reasonable costs are eligible to receive managed care supplemental

payments if they have contracts with DMAP managed care organizations.

(c) Per service reimbursement also known as fee-for-service:

(A) Fee-for-service rates are posted on [www.dhs.state.or.us](http://www.dhs.state.or.us);

(B) AI/AN Tribal Health Care Facilities that choose the fee-for-service methodology may be eligible for an Administrative Match contract with DMAP;

(C) AI/AN Tribal Health Care Facilities that choose the fee-for-service are not eligible for managed care supplemental payments.

(2) 100% of reasonable costs methodology for specific information refer to OARs 410-147-0380, 410-147-0440, 410-147-0480, 410-147-0520, 410-147-0540.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0440 Managed Care Supplemental Payments**

(1) Qualifying AI/AN Tribal Health Care Facilities may receive managed care supplemental payments when the facility has contracts with the Division of Medical Assistance Programs (DMAP) managed care organizations (MCOs).

(2) To receive managed care supplemental payments from DMAP the

AI/AN Tribal Health Facility must submit the following:

(a) When submitting claims to MCOs:

(A) The claims must be submitted within the required timelines outlined in the contract with the MCO;

(B) The AI/AN Tribal Health Care Facility number must be used when submitting all claims to the MCOs. MCOs must accept an AI/AN Tribal Health Care Facility number and may not require individual provider numbers from the facility.

(b) When submitting managed care supplemental payment documentation to DMAP:

(A) Total payments for all services including lab and diagnostic imaging received from the MCO excluding any bonus or incentive payments;

(B) The total number of actual encounters, excluding all lab or diagnostic imaging encounters;

(C) All performing provider numbers that any practitioner associated with the AI/AN Tribal Health Care Facility. Association refers to a practitioner that works for the FQHC or RHC and has or had a private practice and billed DMAP for services;

(D) A current list of all MCO contracts. Must be updated annually and submitted to DMAP each October.

(3) MCO Supplemental Payment process:

(a) On a quarterly basis DMAP will send AI/AN Tribal Health Care Facilities all MCO encounter data received by DMAP electronically in a spreadsheet format along with an explanation letter;

(b) AI/AN Tribal Health Care Facility must review the encounter data and determine if it is complete within 30 days. If it is incomplete, the facility needs to:

(A) Add the missing data to the electronic file and return it with any documentation that can support the missing data to DMAP and the

MCO, and;

(B) Verify that the MCO has the correct provider number for the clinic's claims.

(c) Once the data is reviewed and deemed correct by the AI/AN Tribal Health Care Facility, an interim check will be issued within 30 days for all encounters that DMAP can verify. A letter outlining the settlement and any other pertinent information will accompany the interim check;

(d) The data must be submitted within the timelines provided by DMAP.

(4) The data provided to the AI/AN Tribal Health Care Facility must be carefully reviewed in a timely fashion. If any missing data is not brought to DMAP's attention within the time frames outlined, DMAP will not recalculate an adjustment.

(5) Requests for MCO Supplemental Payments cannot be filed after the end of the required reporting period for that quarter unless DMAP has granted in writing an exception.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-146-0460 Compensation for Outstationed Eligibility Workers**

(1) Compensation may be provided for clinics that are eligible for an Outstationed Outreach Eligibility Worker (OSEW).

(2) Clinics must submit a budget each December 1st to the Division of Medical Assistance Programs (DMAP) for review of the clinic OSEW costs for approval before any OSEW compensation is made each January 1st.

(3) Expenses allowed for OSEW reimbursement:

(a) Salary for each OSEW. To determine which part of the OSEW expense should be charged to DMAP when OSEW has other duties, calculate the percentage of the OSEW total time spent performing eligibility services and multiply it by the total reasonable expenses of the OSEW. This portion of the wages and benefits may be charged to DMAP;

(b) Case management is not part of the OSEW reimbursement. If an OSEW also does case management, calculate the OSEW expense as outlined above;

(c) Travel necessary for DMAP training on OSEW activities;

(d) Phone bills, if a dedicated line. Otherwise an estimate of telephone usage and resulting costs;

(e) Wages for OSEW;

(f) Reasonable equipment necessary to perform outreach activities;  
and

(g) Facility costs. Include a description of the facility area used and if its used for any other activity.

(4) Tribal Facilities that have a Medicaid Administrative Match contract that includes OSEW costs are not eligible for separate OSEW payments.

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Stats. Implemented: ORS 414.065

2-1-07