

Certificate and Order for Filing  
**TEMPORARY ADMINISTRATIVE RULES**  
A Statement of Need and Justification accompanies this form.

I certify that the attached copies\* are true, full and correct copies of the TEMPORARY Rule(s) adopted on \*date signed by the  
Date prior to or same as filing date.

Department of Human Services, Division of Medical Assistance Programs 410  
Agency and Division Administrative Rules Chapter Number

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Address

to become effective 8/1/2011 through 1/25/2011  
Date upon filing or later      A maximum of 180 days including the effective date.

**RULEMAKING ACTION**

**Rule Filing Caption:** Legislatively-approved budget with provider rate changes

**AMEND:** 410-120-1340-General Rules, 410-121-0160- Pharmaceutical Services, 410-122-0186 and 410-122-0630 - DMEPOS, 410-127-0060- Home Health, and 410-130-0595- Medical-Surgical Services

**Statutory Authority:** ORS 413.042

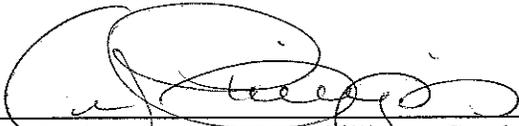
**Other Authority:** SB5529, 2011 State of Oregon Legislative Assembly

**Statutes Implemented:** 414.025, 414.033, 414.065, 414.095, 414.705, 414.727, 414.728, 414.742, 414.743

**Subject Matter:** The Division of Medical Assistance Program administrative rules govern payments for services provided to eligible clients. The General Rules, Pharmaceutical Services, DMEPOS, Home Health Services and Medical-Surgical Services temporarily amended rules listed above to implement rate changes to specified fee-for-service providers to comply with budget limitations required by the 2011 Legislative Assembly in SB 5529. Implementation of these amendments is subject to approval by the Centers for Medicare and Medicaid Services (CMS).

The Division amended the following:

- 410-120-1340- Relative Value Units (RVU) and anesthesia conversion factor
- 410-121-0160- Pharmacy dispensing fee claim volume schedule
- 410-122-0186- DMEPOS fee schedule and utilization limits
- 410-122-0630 –DMEPOS Incontinence utilization limits
- 410-127-0060- Home Health rates (including medical supply daily maximum)
- 410-130-0595- Maternity Case Management - Eliminate reimbursement for both Case Management and High Risk Case Management; and, change Telephone CM Visit to outside home.

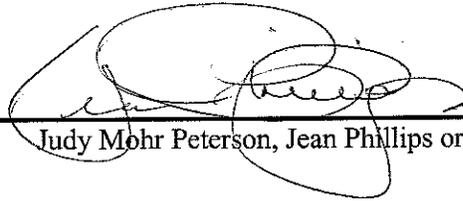
**Authorized Signers:**  7-29-11  
Judy Mohr Peterson, Jean Phillips or Sandy Wood



**Documents Relied Upon, and where these can be viewed or obtained:** SB 5529, 2011 State of Oregon  
Legislative Assembly

**Other Agencies affected:** Oregon's Department of Human Services

**Authorized Signers:**

A large, stylized handwritten signature in black ink, appearing to be a cursive name, is written over a horizontal line.

Judy Mohr Peterson, Jean Phillips or Sandy Wood

7-29-11

Date

## 410-120-1340 Payment

(1) The Division of Medical Assistance Programs (Division) ~~shall~~ will make payment only to the enrolled provider who actually performs the service or to the provider's enrolled billing provider for covered services rendered to eligible clients. Any contracted billing agent or billing service submitting claims on behalf of a provider but not receiving payment in the name of or on behalf of the provider does not meet the requirements for ~~b~~ Billing provider enrollment. If billing agents and billing services intend to submit electronic transactions ~~they will be submitted, billing agents and billing services~~ must register and comply with the Oregon Health Authority (Authority) Electronic Data Interchange (EDI) rules, OAR 407-120-0100 through 407-120-0200. Division reimbursement for services may be subject to review prior to reimbursement. ~~The Division may require that payment for services be made only after review by the Division.~~

(2) The Division (Division of Medical Assistance Programs or another Division within the Authority) ~~Authority division~~ that is administering the program under which the billed services or items are provided sets ~~f~~ Fee-for-service (FFS) payment rates.

(3) The Division uses All FFS payment rates are the rates in effect on the date of service that are the lesser of:

(a) ~~T~~ the amount billed;

(b); ~~T~~ the Division maximum allowable amount or;

(c) ~~the~~ R reimbursement specified in the individual program provider rules:

(Aa) Amount billed may not exceed the provider's "usual charge" (see definitions);

(Bb) The Division's maximum allowable rate setting process uses the following methodology. The rates are updated periodically and posted on the Authority web site at [http://www.oregon.gov/Department/healthplan/data\\_pubs/feeschedule/main.shtml](http://www.oregon.gov/Department/healthplan/data_pubs/feeschedule/main.shtml):

(CA) For all CPT/HCPCS codes assigned a Relative Value Unit (RVU) weight and reflecting services not typically performed in a facility, the Division ~~shall will~~ continue to use ~~convert to~~ the 2010 Transitional Non-Facility Total RVU weights published in the Federal Register, Vol. 74, November 25, 2009 with technical corrections published Dec. 10, 2009, to be effective for dates of services beginning January 1, 2011. For CPT/HCPCS codes for professional services typically performed in a facility the Transitional Facility Total RVU weight ~~Totals~~ shall ~~will~~ be adopted:

(i) The conversion factor for labor and delivery (59400-59622) is \$41.61;

(ii) CPT codes 92340-92342 and 92352-92353 remain at a flat rate of \$26.81;

~~(iii)~~ The conversion factor for -Primary care providers and services is 27.82. A current list of Primary care CPT ,and HCPCS and provider specialty codes is available at [http://www.oregon.gov/OHA/healthplan/data\\_pubs/feeschedule/main.shtml](http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml)  
The document dated:

(l) August 1, 2011, is effective for dates of service on or after August 1, 2011. codes billed by Primary care providers have a conversion factor of \$27.82. See Table XX for list of Primary Care CPT and HCPCS codes and Primary care provider specialties.

~~(iiiv)~~ All remaining RVU weight based CPT/HCPCS codes have a conversion factor of \$27.82~~26.0044~~;

(B) Surgical assist reimburses at 20% of the surgical rate;

(C) The base rate for anesthesia services 00100-01996 is \$ 21.20~~24.19~~ and is based on per unit of service;

~~(D) Clinical lab codes are priced based upon the Centers for Medicare and Medicaid Service (CMS) mandates. Other Non-RVU weight based Lab vary by code are generally between 62% to 97% of Medicare's rates; Clinical lab codes are priced at 70% of the Medicare clinical lab fee schedule;~~

(E) All approved Ambulatory Surgical Center (ASC) procedures are reimbursed at 80% of the Medicare's fee schedule;

(F) Physician administered drugs, billed under a HCPCS code, are based on Medicare's Average Sale Price (ASP). When no ASP rate is listed the rate ~~shall~~will be based upon the Wholesale Acquisition Price (WAC) plus 6.25%. If no WAC is available, then the rate ~~shall~~will be reimbursed at Acquisition Cost. Pricing information for WAC is provided by First Data Bank. These rates may change periodically based on drug costs;

(G) All procedures used for vision materials and supplies are based on contracted rates ~~that~~which include acquisition cost plus shipping and handling;

(c) Individual provider rules may specify reimbursement rates for particular services or items.

(4) The Division reimburses inpatient hospital service under the DRG methodology, unless specified otherwise in the Division's Hospital Services Program administrative rules (chapter 410, division 125). Reimbursement for services, including claims paid at DRG rates, ~~shall~~will not exceed any upper limits established by federal regulation.

(5) ~~The Division Authority~~ reimburses all out-of-state hospital services at Oregon DRG or ~~FFS~~fee-for-service rates as published in the Hospital Services Program rules (OAR chapter 410, division 125) unless the hospital has a contract or service agreement with the Division to provide highly specialized services.

(6) Payment rates for in-home services provided through Department of Human Services (Department) Seniors and People with Disabilities Division (SPD) will not be greater than the current Division rate for nursing facility payment.

(7) ~~The Division Authority~~ sets payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities, psychiatric and rehabilitative care facilities at a rate that is:

(a) Consistent with similar services provided in the State of Oregon; and

(b) The lesser of the rate paid to the most similar facility licensed in the State of Oregon or the rate paid by the Medical Assistance Programs in that state for that service; or

(c) The rate established by SPD for out-of-state nursing facilities.

(8) The Division ~~shall~~ will not make payment on claims that have been assigned, sold, or otherwise transferred or when the billing provider, billing agent or billing service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a provider for accounts receivable.

(9) The Division ~~shall~~ will not make a separate payment or copayment to a nursing facility or other provider for services included in the nursing facility's all-inclusive rate. The following services are not included in the all-inclusive rate (OAR 411-070-0085) and may be separately reimbursed:

(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services Program administrative rules (chapter 410, division 121) and Home Enteral/Parenteral Nutrition and IV Services Program administrative rules, (chapter 410, division 148);

(b) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the appropriate program administrative rules, (chapter 410, division ~~129~~<sup>131</sup> and ~~131~~<sup>129</sup>);

(c) Continuous oxygen which exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Program administrative rules, (chapter 410, division 122);

(d) Influenza immunization serum as described in the Pharmaceutical Services Program administrative rules, (chapter 410, division 121);

(e) Podiatry services provided under the rules in the Medical-Surgical Services Program administrative rules, (chapter 410, division 130);

(f) Medical services provided by a physician or other provider of medical services, such as radiology and laboratory, as outlined in the Medical-Surgical Services Program rules, (chapter 410, division 130);

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Program administrative rules, (chapter 410, division 122).

(10) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSA's). A separate payment will not be made for services included in the core package of services as outlined in OAR chapter 410, division 142.

(11) Payment for Division clients with Medicare and full Medicaid:

(a) The Division limits payment to the Medicaid allowed amount less the Medicare payment up to the Medicare co-insurance and deductible, whichever is less. The Division's payment cannot exceed the co-insurance and deductible amounts due;

(b) The Division pays the Division allowable rate for Division covered services that are not covered by Medicare.

(12) For clients with third-party resources (TPR), the Division pays the Division allowed rate less the TPR payment but not to exceed the billed amount.

(13) The Division payments, including contracted Prepaid Health Plan (PHP) payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For the Division, such payment in full includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding Division allowable payment; and

(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain payment authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual provider rules.

(14) Payment by the Division does not restrict or limit the Authority or any state or federal oversight entity's right to from reviewing or auditing a claim before or after the payment. Claim pPayment may be denied or subject to recovery if medical review, audit or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.033, 414.065, 414.095, 414.705, 414.727, 414.728, 414.742, 414.743

~~1-1-11~~ ~~3-1-11 (Hk)~~

8-1-11 (T)

## 410-121- 0160 Dispensing Fees

(1) Effective August 1, 2011 Professional dispensing fees allowable for services shall be reimbursed as follows:

(a) All enrolled chain affiliated pharmacies shall be reimbursed at a rate of \$9.68 per claim;

(b) Independently owned pharmacies in communities that are the only enrolled pharmacy within a fifteen (15) mile radius from another pharmacy shall be reimbursed at a dispensing fee of \$14.01 per claim;

(c) All other enrolled independently owned pharmacies excluding those in 410-121-0160(b) shall be reimbursed based on an individual pharmacy's annual claims volume as follows:

(Aa) Less than 249,999 claims a year = \$14.01;

(Bb) Between 350,000 and 469,999 claims per year = \$10.14;

(Cc) 570,000 or more claims per year = \$9.68;

(2) All Division enrolled independent pharmacies shall be required to complete an annual survey that collects claim volumes from enrolled pharmacies and other information from the previous 12 month period to determine the appropriate dispensing fee reimbursement:

(a) Claims volume shall be stated by total OHP covered prescriptions and claims from all payer types;

(b) Survey activities shall be conducted by either the Division or its contractor and must be completed and returned by pharmacies within 14 days of receipt;

(c) Completed surveys must be signed with a letter of attestation by the store owner or majority owner;

~~(A) The store owner or majority owner for independent pharmacies;~~

~~(B) The Pharmacy manager and the store manager or a corporate officer for chain pharmacies;~~

(d) Pharmacies that fail to respond to the survey or do not include the letter of attestation shall default to the lowest dispensing tier;

(e) Once a tier is established for a calendar year, the pharmacy's dispensing fee shall remain in that tier until the next annual claims volume survey is conducted;

(f) Newly enrolled independent pharmacies shall be defaulted to the lowest dispensing tier until the next claims volume survey is conducted.

~~(3) Once a tier is established for a calendar year, the pharmacy's dispensing fee shall remain in that tier until the next annual claims volume survey is conducted. All chain affiliated pharmacies shall be exempt from completing the annual claims volume survey.~~

~~(4) Pharmacies newly enrolled with the Division shall be defaulted to the lowest dispensing tier until the next claims volume survey is conducted.~~

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

Stat. Auth.: ORS 184.750, 184.770, 413.042, & 414.065

Stats. Implemented: ORS 414.065

8-1-11 (T)

## **410-122-0186 Payment Methodology**

(1) The Division of Medical Assistance Programs (Division) utilizes a payment methodology for covered durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) which is generally based on the 2010 Medicare's fee schedule.

(a) Division fee schedule amount is 80.0% of 2010 Medicare Fee Schedule for items covered by Medicare and the Division, except for:

(i) Ostomy supplies fee schedule amounts are 95.4% of 2010 Medicare Fee Schedule (See Table 122-0186-1 for list of codes subject to this pricing); and

(ii) Prosthetic and Orthotic fee schedule amounts (L-codes) 83% of 2010 Medicare Fee Schedule; and

(iii) Complex Rehabilitation/Wheelchair fee schedule amounts are 90.5% of 2010 Medicare Fee Schedule (See Table 122-0186-2 for list of codes subject to this pricing);

(b) For items that are not covered by Medicare, but covered by the Division, the fee schedule amount will be calculated by reducing the Division's latest published rates for the year 2010 by 7.6%.

(2) Payment is calculated using the Division fee schedule amount, ~~the manufacturer's suggested retail price (MSRP)~~ or the actual charge submitted, whichever is lowest.

(3) The Division reimburses for the lowest level of service, which meets medical appropriateness. See OAR 410-120-1280 Billing and 410-120-1340 Payment.

(4) Reimbursement for durable medical equipment, miscellaneous (E1399) and other wheelchair accessories (K0108) is capped as follows:

(a) E1399 – \$5772.00;

(b) K0108 – \$11,913.41.

(5) Reimbursement for codes E1399 and K0108 and any code that requires manual pricing is determined as either the lowest amount, verifiable with documentation submitted by DME provider to Division, of the following, plus 20 percent:

(a) Manufacturer's invoice; or 80% of the Manufacturer's Suggested Retail Price (MSRP); or,

(b) Manufacturer's bill to provider; ~~If the MSRP is not available, the lowest amount of the following, plus 20 percent:~~

~~(A) Manufacturer's invoice; or~~

~~(B) Manufacturer's wholesale price; or~~

~~(C) Acquisition cost; or~~

~~(D) Manufacturer's bill to provider;~~

~~(c) If (5) (a) or (b) are not available, reimbursement will be the "estimated price" plus 20 percent. An "estimated price" is the price the provider expects the manufacturer to charge.~~

(6) When requesting prior authorization (PA) for items billed at or above ~~\$400~~150, the DMEPOS provider:

(a) Must submit a copy of:

(A) The items from (5) ~~(a-c)~~(a) or (b) that will be used to bill; and,

(B) Name of the manufacturer, description of the item, including product name/model name and number, serial number if applicable and technical specifications;

(b) May be required to submit a picture of the item.

(7) The DMEPOS provider must submit verification for items billed with codes A4649 (surgical supply; miscellaneous), E1399 (durable medical equipment, miscellaneous) and K0108 (wheelchair component or accessory, not otherwise specified) when no specific Healthcare Common Procedure Coding System (HCPCS) code is available and an item category is not specified in Chapter 410, Division 122 rules. Verification can come from an organization such as the Medicare Pricing, Data Analysis and Coding (PDAC) contractor.

(8) The Division may review items that exceed the maximum allowable/cap on a case-by-case basis. For these situations, the provider must submit the following documentation:

(a) Documentation that supports the client meets all of the coverage criteria for the less costly alternative; and,

(b) A comprehensive evaluation by a licensed clinician (who is not an employee of or otherwise paid by a provider) which clearly explains why the less costly alternative is not sufficient to meet the client's medical needs, and;

(c) The expected hours of usage per day, and;

(d) The expected outcome or change in client's condition.

(9) For codes A4649, E1399 and K0108 when \$150.00 or less per each unit:

(a) Only items that have received an official product review coding decision from an organization such as PDAC with codes A4649, E1399 or K0108 may be billed to the Division. These products may be listed in the PDAC Durable Medical Equipment Coding System Guide (DMECS) DMEPOS Product Classification Lists;

(b) Subject to service limitations of the Division's rules;

(c) PA is not required.

(d) Billed charge to Division must not exceed manufacturer's invoice, or manufacturer's bill to provider plus 20 percent. Provider is required to retain documentation of invoice or bill to allow Division to verify.

Statutory Authority: ORS 413.042 and 414.065

Statutes Implemented: 414.065

7-1-09

7-1-10 (Hk only)

3-1-11 (hk)

8-1-11

Table 122-0186-1: Ostomy Codes priced at 95.4% of 2010 Medicare

<u>Medicare codes</u>	<u>A4392</u>	<u>Non-Medicare</u>	<u>A4417</u>
	<u>A4397</u>	<u>codes (These</u>	<u>A4422</u>
<u>A4361</u>	<u>A5051</u>	<u>are not subject</u>	<u>A4427</u>
<u>A4372</u>	<u>A5062</u>	<u>to reduction)</u>	<u>A4432</u>
<u>A4378</u>	<u>A5081</u>		<u>A5121</u>
<u>A4383</u>	<u>A4369</u>	<u>A4455</u>	<u>A4366</u>
<u>A4390</u>	<u>A4376</u>	<u>A4405</u>	<u>A4408</u>
<u>A4395</u>	<u>A4381</u>	<u>A4410</u>	<u>A4413</u>
<u>A4402</u>	<u>A4388</u>	<u>A4415</u>	<u>A4418</u>
<u>A5054</u>	<u>A4393</u>	<u>A4420</u>	<u>A4423</u>
<u>A5072</u>	<u>A4398</u>	<u>A4425</u>	<u>A4428</u>
<u>A4362</u>	<u>A5052</u>	<u>A4430</u>	<u>A4433</u>
<u>A4373</u>	<u>A5063</u>	<u>A5061</u>	<u>A5122</u>
<u>A4379</u>	<u>A5093</u>	<u>A4363</u>	<u>A4387</u>
<u>A4384</u>	<u>A4371</u>	<u>A4406</u>	<u>A4409</u>
<u>A4391</u>	<u>A4377</u>	<u>A4411</u>	<u>A4414</u>
<u>A4396</u>	<u>A4382</u>	<u>A4416</u>	<u>A4419</u>
<u>A4404</u>	<u>A4389</u>	<u>A4421</u>	<u>A4424</u>
<u>A5055</u>	<u>A4394</u>	<u>A4426</u>	<u>A4429</u>
<u>A5073</u>	<u>A4399</u>	<u>A4431</u>	<u>A4434</u>
<u>A4367</u>	<u>A5053</u>	<u>A5120</u>	<u>A5126</u>
<u>A4375</u>	<u>A5071</u>	<u>A4364</u>	
<u>A4380</u>	<u>A4456</u>	<u>A4407</u>	
<u>A4385</u>		<u>A4412</u>	

Table 122-0186-2: Complex Rehabilitation/Wheelchair Codes priced at 90.5% of 2010 Medicare Fee Schedule.

<u>E0950</u>	<u>E2201</u>	<u>E2362</u>	<u>E2614</u>
<u>E0951</u>	<u>E2202</u>	<u>E2363</u>	<u>E2615</u>
<u>E0952</u>	<u>E2203</u>	<u>E2364</u>	<u>E2616</u>
<u>E0955</u>	<u>E2204</u>	<u>E2365</u>	<u>E2619</u>
<u>E0956</u>	<u>E2206</u>	<u>E2366</u>	<u>E2620</u>
<u>E0957</u>	<u>E2209</u>	<u>E2368</u>	<u>E2621</u>
<u>E0958</u>	<u>E2210</u>	<u>E2369</u>	<u>K0005</u>
<u>E0960</u>	<u>E2211</u>	<u>E2370</u>	<u>K0007</u>
<u>E0966</u>	<u>E2212</u>	<u>E2371</u>	<u>K0015</u>
<u>E0967</u>	<u>E2213</u>	<u>E2373</u>	<u>K0017</u>
<u>E0973</u>	<u>E2214</u>	<u>E2374</u>	<u>K0018</u>
<u>E0974</u>	<u>E2215</u>	<u>E2375</u>	<u>K0020</u>
<u>E0978</u>	<u>E2219</u>	<u>E2376</u>	<u>K0037</u>
<u>E0981</u>	<u>E2221</u>	<u>E2377</u>	<u>K0038</u>
<u>E0982</u>	<u>E2222</u>	<u>E2381</u>	<u>K0039</u>
<u>E0992</u>	<u>E2224</u>	<u>E2382</u>	<u>K0040</u>
<u>E0995</u>	<u>E2225</u>	<u>E2383</u>	<u>K0041</u>
<u>E1002</u>	<u>E2226</u>	<u>E2384</u>	<u>K0043</u>
<u>E1003</u>	<u>E2231</u>	<u>E2385</u>	<u>K0044</u>
<u>E1004</u>	<u>E2310</u>	<u>E2386</u>	<u>K0045</u>
<u>E1005</u>	<u>E2311</u>	<u>E2387</u>	<u>K0046</u>
<u>E1006</u>	<u>E2312</u>	<u>E2388</u>	<u>K0047</u>
<u>E1007</u>	<u>E2313</u>	<u>E2389</u>	<u>K0050</u>
<u>E1008</u>	<u>E2321</u>	<u>E2390</u>	<u>K0051</u>
<u>E1010</u>	<u>E2322</u>	<u>E2391</u>	<u>K0052</u>
<u>E1014</u>	<u>E2323</u>	<u>E2392</u>	<u>K0053</u>
<u>E1015</u>	<u>E2324</u>	<u>E2394</u>	<u>K0056</u>
<u>E1016</u>	<u>E2325</u>	<u>E2395</u>	<u>K0065</u>
<u>E1020</u>	<u>E2326</u>	<u>E2396</u>	<u>K0069</u>
<u>E1028</u>	<u>E2327</u>	<u>E2601</u>	<u>K0070</u>
<u>E1029</u>	<u>E2328</u>	<u>E2602</u>	<u>K0071</u>
<u>E1030</u>	<u>E2329</u>	<u>E2603</u>	<u>K0072</u>
<u>E1161</u>	<u>E2330</u>	<u>E2604</u>	<u>K0073</u>
<u>E1232</u>	<u>E2340</u>	<u>E2605</u>	<u>K0077</u>
<u>E1233</u>	<u>E2341</u>	<u>E2606</u>	<u>K0098</u>
<u>E1234</u>	<u>E2342</u>	<u>E2607</u>	<u>K0733</u>
<u>E1235</u>	<u>E2343</u>	<u>E2608</u>	<u>K0739</u>
<u>E1236</u>	<u>E2351</u>	<u>E2611</u>	<u>K0848</u>
<u>E1237</u>	<u>E2360</u>	<u>E2612</u>	<u>K0849</u>
<u>E1238</u>	<u>E2361</u>	<u>E2613</u>	<u>K0850</u>

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## **410-122-0630 Incontinent Supplies**

(1) The Division of Medical Assistance Programs (Division) may cover incontinent supplies for urinary or fecal incontinence as follows:

(a) Category I Incontinent Supplies –

For up to ~~220~~200 units (any code or product combination in this category) per month, unless documentation supports the medical appropriateness for a higher quantity. For quantities over this limit a prior authorization will be required;

(b) Category II Underpads:

(A) Disposable underpads (T4541 and T4542): For up to 100 units (any combination of T4541 and T4542) per month, unless documentation supports the medical appropriateness for a higher quantity, up to a maximum of 150 units per month;

(B) Reusable/washable underpads: (T4537 and T4540) For up to eight units (any combination of T4537 and T4540) in a 12 month period;

(C) Category II Underpads are separately payable only with Category I Incontinent Supplies;

(D) T4541 and T4542 are not separately payable with T4537 and T4540 for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for eight reusable/washable underpads on a given date of service, a client would not be eligible for disposable underpads for the subsequent 12 months;

(c) Category III Washable Protective Underwear:

(A) For up to 12 units in a 12 month period;

(B) Category III Washable Protective Underwear are not separately payable with Category I Incontinent Supplies for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for 12 units of T4536 on a given date of service, a client would not be eligible for Category I Incontinent Supplies for the subsequent 12 months;

(d) The following services require prior authorization (PA):

(A) A4335 (Incontinence supply; miscellaneous); and

(B) A4543 (Disposable incontinence product, brief/diaper, bariatric, each);

(~~BC~~) Quantity of supplies greater than the amounts listed in this rule as the maximum monthly utilization (e.g., more than ~~220-200~~ units/month of Category I Incontinent Supplies, or 100 gloves/month).

(2) Incontinent supplies are not covered:

(a) For nocturnal enuresis; or

(b) For children under the age of three.

(3) A provider may only submit A4335 when there is no definitive Healthcare Common Procedure Coding System (HCPCS) code that meets the product description.

(4) Documentation requirements:

(a) The client's medical records must support the medical appropriateness for the services provided or being requested by the medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider, including, but not limited to:

(A) For all categories, the medical reason and condition causing the incontinence; and

(B) When a client is using urological or ostomy supplies at the same time as codes specified in this rule, information which clearly corroborates the overall quantity of supplies needed to meet bladder and bowel management is medically appropriate;

(C) When requesting PA for T4543 (Bariatric Brief/Diaper) submit product information showing that item is size XXL or larger. The request shall also include client weight and measurements that support the use of the bariatric incontinence product. (e.g. client weight, waist/hip size) These items are manually priced and follow payment methodology outlined in OAR 410-122-0186.

(b) For services requiring PA, submit documentation as specified in (4)(a)(A), ~~and (B)~~ and (C);

(c) The DMEPOS provider is required to keep supporting documentation on file and make available to the Division on request.

(5) Quantity specification:

(a) For PA and reimbursement purposes, a unit count for Category I – III codes is considered as single or individual piece of an item and not as multiple quantity;

(b) If an item quantity is listed as number of boxes, cases or cartons, the total number of individual pieces of that item contained within that respective measurement (box, case or carton) must be specified in the unit column on the PA request. See table 122-0630-2;

(c) For gloves (Category IV Miscellaneous), 100 gloves equal one unit.

(6)Table 122-0630-1

(7)Table 122-0630-2

Statutory Authority: ORS 413.042 and 414.065

Statutes Implemented: 414.065

7-1-10

3-1-11 (hk)

8-1-11 (T)

**Table 122-0630-1      Incontinent Supplies**

For the code legend see OAR 410-122-0182

<b>Code</b>	<b>Description</b>	<b>PA</b>	<b>PC</b>	<b>RT</b>	<b>MR</b>	<b>RP</b>	<b>NF</b>
<b>CATEGORY I – Incontinent Supplies</b>							
A4335	Incontinence supply; miscellaneous	PA	PC				
T4521	Adult-sized disposable incontinence product, brief/diaper, small, each		PC				
T4522	Adult-sized disposable incontinence product, brief/diaper, medium, each		PC				
T4523	Adult-sized disposable incontinence product brief/diaper, large, each		PC				
T4524	Adult-sized disposable incontinence product, brief/diaper, extra large, each		PC				
T4525	Adult-sized disposable incontinence product, protective underwear/pull-on, small size, each		PC				
T4526	Adult-sized disposable incontinence product, protective underwear/pull-on, medium size, each		PC				
T4527	Adult-sized disposable incontinence product, protective underwear/pull-on, large size, each		PC				
T4528	Adult-sized disposable incontinence product, protective underwear/pull-on, extra large size, each		PC				
T4529	Pediatric-sized disposable incontinence product, brief/diaper, small/medium, each		PC				

**Table 122-0630-1 Incontinent Supplies**

For the code legend see OAR 410-122-0182

<b>Code</b>	<b>Description</b>	<b>PA</b>	<b>PC</b>	<b>RT</b>	<b>MR</b>	<b>RP</b>	<b>NF</b>
T4530	Pediatric-sized disposable incontinence product, brief/diaper, large, each		PC				
T4531	Pediatric-sized disposable incontinence product, protective underwear/pull-on, small/medium size, each		PC				
T4532	Pediatric-sized disposable incontinence product, protective underwear/pull-on, large size, each		PC				
T4533	Youth-sized disposable incontinence product, brief/diaper, each		PC				
T4534	Youth-sized disposable incontinence product, protective underwear/pull-on, each		PC				
T4535	Disposable liner/ shield/ guard/ pad/ undergarment, for incontinence, each <ul style="list-style-type: none"> <li>■ Including but not limited to: pant liner, insert, insert pad, shield, pad, guard, booster pad, or belt-less undergarment</li> </ul>		PC				
T4538	Diaper service, reusable diaper, each diaper		PC				
T4543	Disposable incontinence product, brief/diaper, bariatric, each	<u>PA</u>	PC				

**Table 122-0630-1      Incontinent Supplies**

For the code legend see OAR 410-122-0182

<b>Code</b>	<b>Description</b>	<b>PA</b>	<b>PC</b>	<b>RT</b>	<b>MR</b>	<b>RP</b>	<b>NF</b>
<b>CATEGORY II – Underpads</b>							
T4537	Incontinence product, protective underpad, reusable, bed size, each		PC				
T4540	Incontinence product, protective underpad, reusable, chair size, each		PC				
T4541	Incontinence product, disposable, large, each (more than 394 square inches)		PC				
T4542	Incontinence product, disposable, small, each (less than or equal to 394 square inches)		PC				
<b>CATEGORY III – Washable Protective Underwear</b>							
T4536	Incontinence product, protective underwear/pull-on, reusable, any size, each		PC				
<b>CATEGORY IV - Miscellaneous</b>							
A4927	Gloves, non-sterile, per 100 (50 pairs) <ul style="list-style-type: none"><li>■ Limited to <u>42</u> units (<del>200-100</del> pairs) per month</li><li>■ Covered only when directly related to usage of incontinent supplies</li></ul>		PC				

**Table 122-0630-2      Incontinent Supplies**

**How to count units/pieces when requesting prior authorization (PA) –  
Sample**

<b>Container description</b>	<b>Individual pieces (count)</b>	<b>Units considered for PA</b>
1 box of diapers	10	10
1 box of gloves	100 pieces (50 pairs)	100 gloves = 1 unit

## 410-127-0060 Reimbursement and Limitations

(1) Reimbursement. The Division of Medical Assistance Programs (Division) reimburses home health services on a fee schedule by type of visit (see home health rates and copayment chart on the Oregon Health Authority (OHA) Web site at: <http://www.dhs.state.or.us/policy/healthplan/guides/homehealth/main.html>).

(2) ~~The Division recalculates its home health services rates every other year.~~ The Division ~~shall~~will reimburse home health services at a level of ~~75~~74% of Medicare costs reported on the audited or most recently accepted (~~pending the Centers for Medicare and Medicaid Services, CMS, approval~~) Medicare Cost Reports that were available to the Division in November of 2009, prior to the rebase date.

(3) At the Division's discretion, the Division may recalculate its home health rates every other year. The Division ~~may~~will request the Medicare Cost Reports from home health agencies with a due date, and ~~may~~will recalculate rates based on the Medicare Cost Reports received by the requested due date. It is the responsibility of the home health agency to submit requested cost reports by the date requested.

(4) The Division reimburses only for service which is medically appropriate.

(5) Limitations:

(a) Limits of covered services:

(A) Skilled nursing visits are limited to two visits per day with payment authorization;

(B) All therapy services are limited to one visit or evaluation per day for physical therapy, occupational therapy or speech and language pathology services. Therapy visits require payment authorization;

(C) The Division will authorize home health visits for clients with uterine monitoring only for medical problems, which could adversely affect the pregnancy and are not related to the uterine monitoring;

(D) Medical supplies must be billed at acquisition cost and the total of all medical supplies revenue codes may not exceed \$7550 per day. Only supplies that are used during the visit or the specified additional supplies used for current client/caregiver teaching or training purposes as medically necessary are billable. Client visit notes must include documentation of supplies used during the visit or supplies provided according to the current plan of care;

(E) Durable medical equipment must be obtained by the client by prescription through a durable medical equipment provider.

(b) Not covered service:

(A) Service not medically appropriate;

(B) A service whose diagnosis does not appear on a line of the Prioritized List of Health Services which has been funded by the Oregon Legislature (OAR 410-141-0520);

(C) Medical Social Worker service;

(D) Registered dietician counseling or instruction;

(E) Drug and or biological;

(F) Fetal non-stress testing;

(G) Respiratory therapist service;

(H) Flu shot;

(I) Psychiatric nursing service.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

~~1-1-11~~

~~3-1-11 (Hk stats)~~

8-1-11

## **410-130-0595 Maternity Case Management**

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

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

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

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

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

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

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

(23) This program:

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

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

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

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

(e) Allows billing of intensive nutritional counseling services.

(34) 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.

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

(56) Definitions:

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

(b) Case Management Visit -- A face-to-face encounter between a Maternity Case Manager and the client that must include two or more specific training and education topics, address the CSP and provide an on-going relationship development between the client and the visiting provider.

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

(d) High Risk Case Management -- Intensive level of services provided to a client identified and documented by the Maternity Case Manager or prenatal care provider as being high risk;

(e) High Risk Client -- A client who has a current (within the last year) documented alcohol, tobacco or other drug (ATOD) abuse history, or who is 17 or under, or has other conditions identified by the case

manager anytime in the Initial Assessment or during the course of service delivery;

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

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

(h) Nutritional Counseling -- Intensive nutritional counseling for clients who have at least one of the conditions listed under Nutritional Counseling (1245)(a)(A-I) in this rule;

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

(j) ~~Telephone Case Management Visit~~ Outside the Home -- An ~~non-~~face-to-face encounter outside the client's home between a Maternity Case Manager and the client where providing identical services of a Case Management Home Visit (G9012) are provided.

(67) Maternity case manager qualifications:

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

(A) Physician;

(B) Physician assistant;

(C) Nurse practitioner;

(D) Certified nurse midwife;

(E) Direct entry midwife;

(F) Social worker; or

(G) Registered nurse;

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

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

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

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

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

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

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

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

(89) Documentation requirements:

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

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

(940) G9001 -- Initial Assessment must be performed by a licensed maternity case manager as defined under (67)(a)(A-G) in this rule:

(a) Services include:

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

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

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

(i) A prenatal care provider;

(ii) A dental health provider;

(D) Forwarding the Initial Assessment and the CSP to the prenatal care provider;

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

(b) Data sources relied upon may include:

(A) Initial Assessment;

(B) Client interviews;

(C) Available records;

(D) Contacts with collateral providers;

(E) Other professionals; and

(F) Other parties on behalf of the client;

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

(d) The Initial Assessment (G9001) is billable once per pregnancy per provider and must be performed before providing any other MCM services. Only a Home/Environmental Assessment (G9006) and a Case Management Home Visit (G9012) or Case Management Visit Outside the Home (G9011) may be performed and billed on the same day as an Initial Assessment.

(~~1044~~) G9002 -- Case Management (~~Full Service~~)—includes:

(a) Face-to-face client contacts;

(b) Implementation and monitoring of a CSP:

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

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

(c) Care coordination as follows:

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

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

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

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

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

(B) Provide linkage to labor and delivery services;

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

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

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

(A) Ask all clients about smoking status;

(B) Advise all smoking clients to quit;

(C) Assess for readiness to try to quit;

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

(E) Arrange follow-up for interventions;

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

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

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

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

(jk) G9002 is billable once per pregnancy.

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

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

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

~~(11)(13) G9005 -- High Risk Case Management (Full Service):~~

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

~~-(b) A client can be identified as high risk at any time when case management services are provided, therefore G9005 can be billed after 3 months of case management services.~~

~~\_High Risk Case Management services are provided for the client for more than three months after the client was identified as high risk; and~~

~~\_(c) Client is provided at least eight Case Management Visits;~~

~~(cd) G9005 is billable after the delivery and only once per pregnancy per provider.;~~

~~(d) G9002 can not be billed in addition to G9005. (e) G9005 can be billed in addition to G9002.~~

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

~~(a) Are the same enhanced level of services provided in G9005 but the client became high risk during the latter part of the pregnancy or intensive high risk MCM services were initiated and partially completed but not carried through to the date of delivery;~~

~~-(b) Are high risk case management services provided to the client for three months or less after the client has been identified as high risk; or (c) Is billed when the client is provided less than eight Case Management Visits;~~

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

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

~~(12)(15) S9470 -- Nutritional counseling:~~

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

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

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

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

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

(E) Eating disorder;

(F) Gestational diabetes;

(G) Hyperemesis;

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

(I) Other identified conditions;

(b) Documentation must include all of the following:

(A) Nutritional assessment;

(B) Nutritional care plan;

(C) Regular client follow-up;

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

(d) S9470 is billable only once per pregnancy.

(13)~~(16)~~-G9006 -- Home/Environmental Assessment:

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

(b) G9006 may be billed only once per pregnancy, except an additional Home/Environmental Assessments may be billed with documentation of problems which necessitate follow-up assessments or when a client moves. Documentation must be submitted with the claim to support the additional Home/Environment Assessment.

~~(14)(17)~~ G9011 -- ~~Telephone Case Management Visit~~ Outside the Home:

(a) A ~~non~~-face-to-face encounter between a maternity case manager and the client in a place other than the home which meets, meeting all requirements of a Case Management Home Visit (G9012) or ~~and~~ when a telephone encounter when a face-to-face Case Management Visit is not possible or practical;

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

~~(15)(18)~~ G9012 – Case Management Home Visit:

(a) Each Case Management Home Visit must be performed in the client's home and must include:

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

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

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

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

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

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

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

~~(16)(19) Table 130-0595-1~~

~~(17)(20) Table 130-0595-2~~

Stat. Auth.: ORS 409.050 and 414.065

Stats. Implemented: ORS 414.065

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

## 7-1-10Table 130-0595-1 Environmental Assessment

### **Housing Characteristics**

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

### **General Safety**

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

### **Food Safety**

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

### **Toxins/Teratogens**

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

### **Indoor Air**

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

Asbestos

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

### **Fire Prevention**

Fire hazards: smoking, candles and flammable item storage

Electrical outlets

### **Emergency Planning**

Smoke alarms: installed and working

Adequate exits: all locations and free of obstacles

Emergency preparedness: escape plan; emergency numbers posted; adequate food, water and supplies; alternate heating, lighting and cooking capability

Transportation

### **Occupations & Hobbies**

Employment, such as: nail salons, painters, remodelers, home repair, radiator repair, dry cleaning, gardener, pesticide applicator, farm/orchard worker, landscape worker

Hobbies, such as: making and using fishing weights or bullets; shooting or cleaning at indoor shooting ranges

### **Miscellaneous**

Pets: presence or care of dogs, cats, birds, reptiles (lizards & snakes) and turtles

Cleaning of cat litter box and other pet cages

Administering flea or tick treatments to pets

Pests: presence or management of mice, rats, insects, bedbugs, etc.

## Table 130-0595-2 MCM Training and Education Topics

### **MANDATORY TOPICS**

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

### **NON-MANDATORY TOPICS**

#### **Pregnancy and Childbirth**

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

#### **Health Status**

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

#### **Environmental Health**

Housing  
Safety and sanitation  
Toxins/Teratogens  
Occupational exposures  
Drinking water

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

### **Parenting**

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

### **Other Topics**

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