

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING
A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority (OHA), Division of Medical Assistance Programs (Division)	410	
Agency and Division	Administrative Rules Chapter Number	
Sandy Cafourek	500 Summer St NE, Salem, OR 97301	(503) 945-6430
Rules Coordinator	Address	Telephone

RULE CAPTION

Allow Use of Medical Billing Codes Designated for Adaptive Behavior Assessment and Treatment Services
Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

March 17, 2015	10:30 a.m.	500 Summer St. NE, Salem, OR 97301 Room 160	Sandy Cafourek
Hearing Date	Time	Location	Hearings Officer

Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND: OAR 410-130-0160

REPEAL:

RENUMBER:

AMEND & RENUMBER:

Stat. Auth. : ORS 413.042

Other Auth.:

Stats. Implemented: ORS 414.025, 414.065

RULE SUMMARY

This rule directs medical providers to use billing codes following national standards and identifies which code sets are appropriate. One aspect of the current rule prevents use of Category III CPT Codes – a code set designated for services or technologies that are new and need to be tracked for data collection. The Division has identified that the billing codes for Adaptive Behavior Assessment and Treatment services found within the Category III CPT Code set are the most appropriate codes to use for billing ABA therapy. This rule change will allow use of these ABA therapy related billing codes. It will continue to restrict use of the remaining Category III codes.

The agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

March 19, 2015 by 5 p.m. Send written comments to: dmap.rules@state.or.us

Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

		
Signature	Printed name	Date

Note: Hearing Notices must be submitted by the 15th day of the month to be published in the next month's *Oregon Bulletin*.

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division)	410
Agency and Division	Administrative Rules Chapter Number

Allow Use of Medical Billing Codes Designated for Adaptive Behavior Assessment and Treatment Services
Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The amendment of OAR 410-130-0160

Statutory Authority: ORS 413.042

Other Authority:

Stats. Implemented: ORS 414.025, 414.065

Need for the Rule(s): These codes will be needed for claims processing January 1, 2015 when the new Health Evidence Review Commission's Prioritized List takes effect and Category III codes will be used to bill for Applied Behavioral Analysis (ABA) treatment. They are currently allowed under a temporary rule. This rule will make the temporary rule permanent.

Documents Relied Upon, and where they are available: *Current Procedural Terminology (CPT®)* copyright 2014 American Medical Association and January 1, 2015 Health Evidence Review Commission's Prioritized List

Fiscal and Economic Impact: There are no known fiscal or economic impacts of opening up the Category III codes as opposed to opening up other codes that might also be chosen for this service. The financial impact of ABA services in general has been estimated to run around \$56,000,000 a year before federal match.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): There are no known, direct costs associated with these rules changes.

2. Cost of compliance effect on small business (ORS 183.336):
 - a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule: Approximately 10-20 small business providers are subject to this rule currently. We are hoping that more small business providers will move to the state in the near future, so this number could rise considerably. However there are no known, direct costs associated with these rule changes.

 - b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: None

 - c. Equipment, supplies, labor and increased administration required for compliance: None

How were small businesses involved in the development of this rule? Many of the people attending the RAC were providers running small businesses. Other providers have been questioned about the impact of these rules changes by telephone and email. Small business providers will continue to be involved in the development of all aspects of the ABA treatment program both formally and informally.

Administrative Rule Advisory Committee consulted?: Yes. If not, why?:

	DAVID SUMMIT	1/28/2015
Signature	Printed name	Date

410-130-0160

Codes

(1) ICD-9-CM Diagnosis Codes:

(a) Always use the principal diagnosis code in the first position to the highest degree of specificity. List up to three additional diagnosis codes if the claim includes charges for services that relate to the additional diagnoses. All codes need to be reported to the highest degree of specificity. However, it is not necessary to include more than one diagnosis code per procedure code;

(b) Diagnosis codes are required on all billings including those from independent laboratories and portable radiology including nuclear medicine and diagnostic ultrasound providers;

(c) Always supply the ICD-9-CM diagnosis code to ancillary service providers when prescribing services, equipment, and supplies.

(2) CPT, and HCPCS Codes:

(a) Use only codes from the current year for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes;

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

(c) CPT category II (codes with fifth character of "F") and CPT category III codes (codes with fifth character "T") are not Division of Medical Assistance Programs' (Division) covered services, with the exception of the Category III codes included under the following headings: Adaptive Behavior Assessments, Adaptive Behavior Treatment, and Exposure Adaptive Behavior Treatment with Protocol Modification;

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

(3) The Medical-Surgical Service rules list the 2005-HCPCS/CPT codes that require prior authorization, or have limitations. The Health Services Commission's Health Evidence Review Commission's Prioritized List of Health Services (rule 410-141-0520) determines covered services.

(4) For determining the appropriate level of service code for Evaluation and Management services, read the definitions in the CPT and HCPCS-codebook. Use the

definitions CPT guidelines to verify your the level of service, especially for office visits. Unless otherwise specified in the Medical-Surgical provider rule, use the guidelines from CPT and HCPCS.

(5) Bundled Services—; Reimbursements for some services are “bundled” into the payment for another service. (e.g., payment for obtaining a PAP smear is bundled into the payment for the office visit). ~~Bundled services cannot be billed separately to t~~The Division of Medical Assistance Programs (Division) does not make separate payment for bundled services, and or the c~~lients may not be billed for bundled services. The abbreviation “BND” in the code lists in the Division’s Medical-Surgical Services Not Covered/Bundled Services provider rule provides more information regarding bundled services (OAR 410-130-0220 Not Covered/Bundled Services).~~ indicates the procedure is bundled into another one.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065