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# Code groups for claim processing

Managing codes for fee-for-service claim processing  
and payment purposes



Health Systems Division

June 2016

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# Introduction

- Services included in the minimum benefit\*
  - Code pairings above the funding line on the Prioritized List
  - Codes not on the Prioritized List
    - Diagnostic services (OAR 410-141-0480(3))
    - Ancillary to covered services (OAR 410-141-0480(6))
- Services not included in the minimum benefit
  - Code pairings below the funding line on the Prioritized List
  - Excluded services not on the Prioritized List (OAR 410-120-1200)

\* When medically appropriate and subject to relevant HERC guideline notes

# Fee-for-service (FFS) code management strategy

- Payment
  - FFS (and CCOs) must have a pathway to access for all covered services, if medically appropriate
  - FFS has a near 1:1 relationship between covered codes and payable codes
  - Exceptions to the 1:1 relationship
    - Bundled codes
    - Multiple code options for the same service
- Adjudication
  - Prioritized List codes\* are loaded into the MMIS
  - Non-Prioritized List codes are grouped in MMIS and restrictions hit against the groups

\* Not part of today's discussion

# Recent FFS changes – October 2015

- New codes for all ICD-10 diagnostic code groups
- FFS reorganized diagnostic code groups to add clarity

Because of these changes, it is inevitable that there are errors in some of these groups. These errors do not negate our obligation to follow the Oregon Administrative Rules (OARs) regarding covered services

# Old Prioritized List code groups\*

- Exempt: indicated the specific code was not found on the List, but ALWAYS covered
- Excluded: indicated the specific code was not found on the List, but NEVER covered
- Diagnostic: the nature of the procedure is to find the diagnosis; most diagnostic tests are covered
- Ancillary: codes that are in support of a covered service (i.e. anesthesia, wheelchair)

\* These groups were not published

# Medical-Surgical Services Program

<http://www.oregon.gov/oha/healthplan/Pages/medical-surgical.aspx>

- Supplemental information and guidelines
- More specific code groups for claim processing
  - Not Covered/Bundled/Not Valid Procedures (Procedure Group 1118)
  - Undefined Diagnosis Codes (Diagnosis Code Group 6030)
  - Informational Diagnosis Codes (Diagnosis Code Group 6033)
  - Diagnostic Workup File (Diagnosis Code Group 6032)
  - Diagnostic Procedure Codes (Procedure Code Group 1119)
  - Conditions Not Covered (Diagnosis Code Group 6031)

Additional, currently not published procedure group: ancillary (6060)

Current Procedural Terminology (CPT) and Healthcare Common  
Procedure Coding System (HCPCS)

# PROCEDURE CODE GROUPS

# Not Covered/Bundled/Not Valid

- Oregon Administrative Rule (OAR) [410-130-0220](#); Table [130-0220-1](#) (Coming soon – Excel version)
- Three indicators
  - N: Non-covered services
  - B: Bundled
  - NV: Not valid (another coding option must be used)

# Diagnostic procedures

- Most are not included on the Prioritized List (i.e. lab testing, imaging)
- Covered by FFS program when billed with a diagnosis code from the Diagnostic Workup File, above the funding line, and below the funding line.

# Ancillary procedures

- Currently unpublished
- Anything in support of a covered service (i.e. anesthesia)
- Covered when the diagnosis is above the line (i.e. vaccine administration is above the line on the Prioritized List, but the specific substance is not)

International Classification of Diseases (ICD)

# DIAGNOSIS CODE GROUPS

# Undefined diagnoses

- Diagnosis codes that are not clear enough for processing
- These used to be part of the excluded list (old term)

# Informational diagnoses

- Diagnosis codes that are intended to add extra information, but do not determine payment (i.e. primary Dx for contracted hand; additional codes stating why the hand is contracted, family/ personal history, etc.)
- Claim processing is denied if one of these codes is primary
- Not on the Prioritized List

# Work-up diagnoses

- Diagnoses not specific enough to start treatment, but enough concern to begin diagnostic services (i.e. chest pain, uncontrollable cough, etc.)
- Linked with (payment decision is based upon) diagnostic procedure list; when the diagnosis is on the work-up file, and
  - The procedure is on the diagnostic procedure list, FFS pays
  - The procedure is treatment-oriented (not on the diagnostic procedure list), FFS denies. We expect a more specific diagnosis
- These used to be part of the exempt diagnosis list (old term)

# Conditions not covered

- Diagnoses that are never paid on a FFS basis (i.e. infertility)
- These used to be part of the excluded diagnosis list (old term)

Prioritized List of Health Services

# RESOURCES

# Resources

## Benefit RN Hotline

Toll-free      800-393-9855

Local          503-945-5939

## Medicaid Provider Training

[Medicaid.provider-training@state.or.us](mailto:Medicaid.provider-training@state.or.us)

# Strategies for Providing Lactation Services

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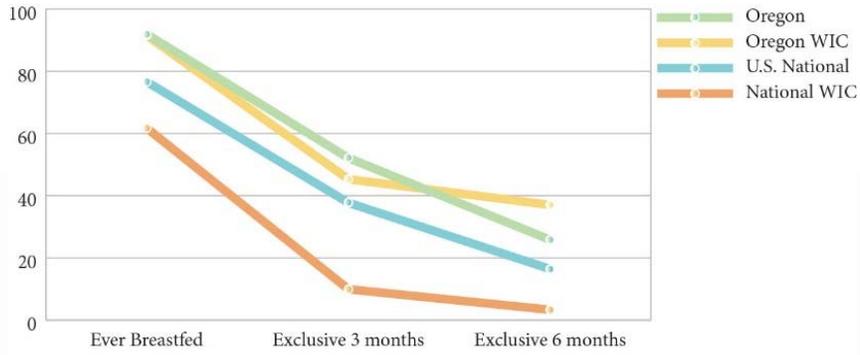


## Background

- *Affordable Care Act* – enacted March 2010
- *August 2012*: ACA/DHHS final rules requiring health insurance plans to cover certain women’s preventive health services, including “breastfeeding support, supplies, and counseling.”
- *January 2015*: HERC Guideline note 140: Breastfeeding Support and Supplies, Line 3 – guidance on required lactation services and breastfeeding equipment
- *July 2015*: WIC staff presented at QHOC on coordination of provision of breast pumps to women with Medicaid/WIC
- *Fall & Winter 2015-16*: Public health led a workgroup to identify strategies, best practice models and Oregon examples of provision of lactation services

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## U.S. and Oregon Breastfeeding Rates



### Strategies for Providing Lactation Services An Evidence-Based Guide for CCOs



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**Oregon Health Authority**

## Strategy 1

Establish a written infant feeding policy that supports breastfeeding as the normative standard for infant feeding.



## Strategy 2

Use qualified breastfeeding support and lactation care providers to offer comprehensive breastfeeding services.



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## Strategy 3

Maximize the local network of qualified breastfeeding support and lactation care providers.



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## Strategy 4

Provide comprehensive breastfeeding support and lactation care during pregnancy, at birth, and postpartum.



4

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## Strategy 5

Develop billing, reimbursement and coding systems that support the effective delivery of comprehensive breastfeeding support and lactation care.



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## Appendices

- Selected examples of Medicaid Coverage for Lactation Services & Supplies (other states)
- Summary of Oregon Lactation Services Survey December 2015

## Next Steps

- Encourage CCOs to share this resource with your OB/Gyn, Family Practice and Pediatric providers
- Best to send out electronically to take advantage of extensive online resources linked in the document
- Encourage local providers to reach out to their community's WIC and MCH programs and local breastfeeding coalitions to coordinate lactation care

# Questions?