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TEMPORARY ADMINISTRATIVE ORDER

INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 17-2020

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

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ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Amends Medical Services Rule For Planned Out Of Hospital Birth Requests During Coronavirus Emergency

EFFECTIVE DATE: 04/01/2020 THROUGH 09/27/2020

AGENCY APPROVED DATE: 04/01/2020

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NEED FOR THE RULE(S):

The Division needs to amend this rule to support appropriate response during an outbreak or epidemic of an infectious disease. This amended rule provides alternate criteria for coverage During the state of emergency under governor Kate Brown's executive order 20-03, to improve access to care, reduce exposure to COVID-19 and potentially reduce hospital utilization. The amended rule authorizes the Division to operationalize revised coverage criteria for planned out of hospital birth services based on a draft coverage guidance under development by the Health Evidence Review Commission.

JUSTIFICATION OF TEMPORARY FILING:

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, and recipients of Medicaid benefits. These rules need to be adopted promptly so that the Authority may operationalize the intent of the Health Evidence Review Commission's (HERC) draft coverage guidance on planned out of hospital birth. This rule needs to be adopted promptly in order to support appropriate response to an outbreak or epidemic of infectious disease and assure appropriate access to qualified health care providers and reduce disease transmission.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Draft HERC coverage guidance at
https://www.oregon.gov/oha/HPA/DSI-HERC/EvidenceBasedReports/CG-OOHB-02-11-20.pdf

AMEND: 410-130-0240

RULE TITLE: Medical Services

RULE SUMMARY: This rule identifies coverage criteria for various medical-surgical services for fee-for-service clients. These updates support appropriate response to an outbreak or epidemic of an infectious disease through increased

access to appropriate health care resources. This temporary rule amendment authorizes the Division provide less restrictive criteria for coverage of planned out-of-hospital births during the During the state of emergency under governor Kate Brown's executive order 20-03.

RULE TEXT:

(1) Coverage of medical and surgical services is subject to the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List). Medical and surgical services requiring prior authorization (PA) are listed in Oregon administrative rule (OAR or rule) 410-130-0200, PA Table 130-0200-1, and medical and surgical services that are Not Covered/Bundled services are listed in OAR 410-130-0220, Table 130-0220-1.

(2) Coverage for acupuncture services by an enrolled acupuncture provider are subject to the HERC Prioritized List and the client's benefit plan.

(3) Coverage for medically appropriate chiropractic services provided by an enrolled chiropractor is subject to the HERC Prioritized List and benefit plan for:

(a) Diagnostic visits including evaluation and management services;

(b) Chiropractic care including manipulative treatment;

(c) Laboratory and radiology services.

(4) Maternity care and delivery:

(a) The Division may consider payment for delivery within a hospital, clinic, birthing center, or home setting;

(b) For out-of-hospital births, the Division may only consider payment for labor and delivery care of women experiencing low risk pregnancy. The Division will determine whether a pregnancy can be considered low risk and an out-of-hospital birth is eligible for payment;

(c) During the Coronavirus (COVID-19) outbreak state of emergency initiated under governor Kate Brown's executive order 20-03 and any subsequent executive order extending the state of emergency, the division adopts tables 410-130-0240-1, 410-130-0240-2, 410-130-0240-3 and 410-130-0240-4, superseding the requirements in the Prioritized List of Health Services Guideline Note 153 for the purposes described below.

(d) During the Coronavirus (COVID-19) outbreak state of emergency initiated under governor Kate Brown's executive order 20-03 and any subsequent executive order extending the state of emergency, the division adopts Table 410-130-0240-1 and Table 410-130-0240-3 to outline the absolute risk factors that, if present, would preclude payment for initiation or continuation of any out-of-hospital labor and delivery care. For a planned out-of-hospital birth, the Division requires that a contingency for an in-hospital birth be included in the medical record. The division considers all conditions listed in Tables 410-130-0240-1 and 410-130-0240-3 to necessitate an in-hospital birth if present or anticipated to be present at the onset of labor. The Division may deny payment for labor and delivery services in an out-of-hospital setting if it determines that an in-hospital birth was necessary and appropriate steps to facilitate an in-hospital birth were not pursued. The Division may also deny payment for services if appropriate risk assessments were not performed at initiation of care and throughout pregnancy, or when the appropriate consultation policies described in subsection (e) were not followed. When an in-hospital birth becomes necessary for a client that was seeking a planned out-of-hospital birth and care is transferred from one provider to another, the Division will consider payment for both providers for the portion of care provided. Bill using appropriate CPT and HCPCS codes.

(e) During the Coronavirus (COVID-19) outbreak state of emergency initiated under governor Kate Brown's executive order 20-03 and any subsequent executive order extending the state of emergency, the division adopts Table 410-130-0240-2 and Table 410-130-0240-4, which contain criteria requiring consultation regarding the management of risk factors during pregnancy and birth for patients receiving out-of-hospital birth care. The division may deny payment if any of the high-risk conditions in tables 410-130-0240-2 or 410-130-0240-4 arise during pregnancy, labor, delivery or the immediate postpartum period and no consultation with an appropriate provider occurs, or if the recommendations of the consulting provider are not adhered to by the out-of-hospital birth attendant in the out-of-hospital setting. For the purposes of consultation under this subsection, an appropriate consulting provider is one of the following:

A) A provider (MD/DO or CNM) who has active admitting privileges to manage pregnancy in a hospital, or;

B) An appropriate specialty consultant (e.g., maternal-fetal medicine, hepatologist, hematologist, psychiatrist).

(f) When a provider is practicing within the authorization of his or her license, the division may consider payment for administration of drugs and devices that are used in pregnancy, birth, postpartum care, newborn care, or resuscitation and that are deemed integral to providing safe care.
(g) For out-of-hospital births, drugs authorized in subsection (f) or this section are limited:
(A) For out-of-hospital births, the Division will make no payment for general, spinal, caudal, or epidural anesthesia administered for care associated with labor and delivery;
(B) For out-of-hospital births, the Division will make no payment for inducing, stimulating, or using chemical agents to augment labor during the first or second stages of labor;
(C) For out-of-hospital births, the Division will consider payment for chemical agents administered to inhibit labor only as a temporary measure until referral or transfer of the client to a higher level of care is complete.
(h) Within the home setting, the Division may consider payment for appropriate supplies in addition to delivery payment. The additional payment for supplies includes all supplies, equipment, staff assistance, and newborn screening cards;
(i) During labor in an out-of-hospital setting, should any of the risk factors outlined in Table 410-130-0240-3 develop, the Division requires that the client will be transferred to a hospital, and the Division may deny payment for labor and delivery services if it determines that appropriate steps to facilitate the transfer were not pursued. Appropriate transfer of care must be in accordance with the practitioner's licensure requirements. When labor management does not result in a delivery, and the client is appropriately transferred to a higher level of care, the provider shall code for labor management only. Bill code 59899 and attach appropriate clinical documentation of services performed with respect to labor management. The Division may also deny payment for services if appropriate risk assessments were not performed during labor, or when the appropriate consultation policies described in subsection (e) were not followed;
(j) For births in an out-of-hospital setting, should any of the risk factors outlined in Table 410-130-0240-3 develop during the postpartum period in the mother, the Division requires that the mother will be transferred to a hospital, and the Division may deny payment for labor and delivery services if it determines that appropriate steps to facilitate the transfer were not pursued. Appropriate transfer of care must be in accordance with the practitioner's licensure requirements. The Division will consider payment for both providers for the portion of care provided when appropriate. The Division may also deny payment for services if appropriate risk assessments were not performed at initiation of care and throughout pregnancy, or when the appropriate consultation policies described in subsection (e) were not followed;
(k) For multiple vaginal births, use the appropriate CPT code for the first delivery. Use the delivery-only code for the subsequent deliveries. The Division will reimburse the first delivery at 100 percent and the subsequent deliveries at 50 percent of the delivery-only code's maximum allowance. For multiple babies delivered via cesarean section, the Division pays for the cesarean section only once.
(L) The division may deny payment or authorization for planned out-of-hospital birth when conditions arise which in the Division's judgment create a situation in which a planned out-of-hospital birth is not medically appropriate. For example, having multiple risk conditions requiring consultation may increase the risk sufficiently to indicate the need for transfer of care.
(5) Neonatal Intensive Care Unit (NICU) procedures:
(a) Are reimbursed only to neonatologists and pediatric intensivists for services provided to infants when admitted to a Neonatal or Pediatric Intensive Care Unit (NICU/PICU). All other pediatricians must use other CPT codes when billing for services provided to neonates and infants;
(b) Neonatal intensive care codes are not payable for infants on Extracorporeal Membrane Oxygenation (ECMO). Use appropriate CPT ECMO codes.
(6) Neurology or Neuromuscular payment for polysomnograms and multiple sleep latency tests (MSLT) are each limited to two in a 12-month period.
(7) Oral health services provided by medical practitioners may include an oral assessment and application of topical fluoride varnish during a medical visit for children. Refer to OAR 410-123-1260 Dental Services program rule.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.065

Table 130-0240-1: MEDICAL HISTORY OR OBSTETRIC HISTORY (TRANSFER CRITERIA)	
Cancer	• Active gynecologic cancer
Cardiovascular disease	• Cardiovascular disease causing functional impairment
Delivery history	• Prior cesarean section
Diabetes Mellitus	• Type 1 diabetes • Type 2 diabetes
Hematologic disorders	• Maternal bleeding disorder
Hypertensive disorders	• Eclampsia • Pre-eclampsia requiring preterm birth • HELLP syndrome (hemolysis, elevated liver enzymes, low platelets) • Pre-existing or chronic hypertension
Infectious Diseases	• HIV positive
Neurological disorders	• Neurological disorders or active seizure disorders that would impact maternal or neonatal health (e.g. epilepsy, myasthenia gravis, previous cerebrovascular accident)
Placental conditions	• History of retained placenta requiring surgical removal
Renal disease	• Renal disease requiring supervision by a renal specialist • Renal failure *(Preeclampsia and related conditions are listed separately)*
Uterine Conditions	• Prior hysterotomy

Table 130-0240-2: MEDICAL HISTORY OR OBSTETRIC HISTORY (CONSULTATION CRITERIA)	
Connective tissue disorders	• Systemic lupus erythematous • Scleroderma • Rheumatoid arthritis • Any collagen-vascular disease
Endocrine Conditions	• Significant endocrine conditions other than diabetes (e.g. hyperthyroidism)
Fetal demise or stillbirth	• Prior stillbirth/neonatal death
Hematologic disorders	• Hemoglobinopathies • History of thrombosis or thromboembolism • History of postpartum hemorrhage requiring intervention

Table 130-0240-2: MEDICAL HISTORY OR OBSTETRIC HISTORY (CONSULTATION CRITERIA)	
Isoimmunization	• Blood group incompatibility and/or Rh sensitization in a prior pregnancy
Neonatal encephalopathy in prior pregnancy	• Neonatal encephalopathy in prior pregnancy
Psychiatric conditions	• History of postpartum mood disorder with high risk to the infant (e.g. psychosis) • Schizophrenia, other psychotic disorders, bipolar I disorder or schizotypal disorders
Pulmonary disease	• Chronic pulmonary disease (e.g. cystic fibrosis)
Shoulder dystocia	• History of, with or without fetal clavicular fracture
Uterine conditions	• Prior myomectomy

Table 130-0240-3: CONDITIONS OF CURRENT PREGNANCY (TRANSFER CRITERIA)	
Abnormal bleeding in pregnancy	• Antepartum hemorrhage, recurrent • Hemorrhage (hypovolemia, shock, need for transfusion, vital sign instability)
Amniotic membrane rupture	• Before 37 weeks 0 days
Diabetes, gestational	• Requiring medication or uncontrolled
Fetal growth	• Uteroplacental insufficiency • IUGR (defined as fetal weight less than fifth percentile using ethnically-appropriate growth tables, or concerning reduced growth velocity on ultrasound)
Fetal presentation	• Breech or noncephalic presentation
Gestational age	• < 37 weeks 0 days • ≥42 weeks 0 days
Hematologic conditions	• Anemia with hemoglobin < 8.5 g/dL (current pregnancy) • Suspected or diagnosed thrombosis or thromboembolism • Thrombocytopenia (platelets < 100,000)

Hypertensive disorders	• Elevated blood pressure on two occasions 30 minutes apart (e.g. gestational hypertension or pregnancy-induced hypertension)
	  ○ Systolic ≥ 140 or diastolic ≥ 90
	• Elevated blood pressure on one occasion
	  ○ Systolic ≥ 160 or diastolic ≥ 110, or
	  ○ Systolic ≥ 140 or diastolic ≥ 90, with severe pre-eclampsia features
	• Pre-eclampsia
	• Eclampsia
	• HELLP syndrome

Infectious conditions	• HIV, Hepatitis B or syphilis positive • Chorioamnionitis • Maternal temperature ≥ 38.0 C in labor/postpartum • Genital herpes at time of labor • Maternal infection postpartum (e.g., endometritis, sepsis, wound) requiring hospital treatment • Rubella • Tuberculosis (other than latent) • Toxoplasmosis • Varicella (active at labor)

Isoimmunization	• Blood group incompatibility and/or Rh sensitization in current pregnancy
Labor management	• Induction • Failure to progress/failure of head to engage in active labor • Lack of adequate progress in 2nd stage with cephalic presentation
Miscarriage/non-viable pregnancy	• Molar
Multiple gestations	• Multiple gestations
Oligohydramnios or polyhydramnios	• Oligohydramnios • Polyhydramnios
Perineal laceration or obstetric anal sphincter injury	• 3rd degree requiring hospital repair or beyond expertise of attendant • 4th degree • Enlarging hematoma
Placental conditions	• Low lying placenta within 2 cm or less of cervical os at 38 weeks 0 days or later • Placenta previa • Vasa previa • Abruption • Retained placenta > 60 minutes
Substance Use	• Drug or alcohol misuse with high risk for adverse effects to fetal or maternal health
Umbilical cord	• Prolapse
Uterine condition	• Uterine rupture, inversion or prolapse

Table 130-0240-4: CONDITIONS OF CURRENT PREGNANCY (CONSULTATION CRITERIA)	
Amniotic membrane rupture	• Pre-labor rupture > 24 hours
Congenital or hereditary anomaly of the fetus	• Evidence of congenital anomalies requiring immediate assessment and/or management by a neonatal specialist
Fetal growth	• Inappropriate uterine growth (size-date discrepancy). (An ultrasound read by a qualified physician constitutes a consultation).
Gestational age	• Expected date of delivery (EDD) uncertain
Hematologic conditions	• Hemoglobin < 10 g/dL, unresponsive to treatment
Hepatic disorders	• Disorders including uncontrolled intrahepatic cholestasis of pregnancy and/or abnormal liver function tests
Hyperemesis gravidarum	• Refractory
Psychiatric conditions	• Maternal mental illness requiring psychological or psychiatric intervention • Patient currently taking psychotropic medications
Renal	• Acute pyelonephritis
Uterine condition	• Anatomic anomaly (e.g. bicornuate, large fibroid impacting delivery)