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TEMPORARY ADMINISTRATIVE ORDER

INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 54-2020

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

FILED
09/30/2020 9:40 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Amends Medical Services Rule For Maternity Care And Delivery Referencing October 2020 HERC Prioritized List

EFFECTIVE DATE: 10/01/2020 THROUGH 03/29/2021

AGENCY APPROVED DATE: 09/30/2020

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NEED FOR THE RULE(S):

The Division needs to amend this rule to reference updates to the Health Evidence Review Commission's (HERC) Prioritized List of Health Services and Guidelines. This amended rule provides coverage criteria for planned out of hospital births by referencing current guidance developed by HERC which will be adopted and effective October 1, 2020. The amended rule authorizes the Division to operationalize revised coverage criteria for planned out of hospital birth services in alignment with the HERC's intent. A full permanent rule development will occur including public input.

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) coverage guidance, Prioritized List and Guidelines released and effective on October 1, 2020. This rule needs to be adopted promptly in order to assure appropriate access to qualified health care providers.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Draft HERC coverage guidance at:
https://www.oregon.gov/oha/HPA/DSI-HERC/PrioritizedList/10-1-2020%20Prioritized%20List%20of%20Health%20Services.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. Coverage of services for planned out of hospital births includes assessing pregnancy risk. The Health Evidence Review Commission (HERC) will adopt published updates to the Prioritized List and Guidelines which define pregnancy risk criteria which will be effective October 1, 2020. This temporary rule amendment authorizes the Division to adopt the

HERC's Prioritized List and Guidelines to operationalize HERC's intent for coverage of planned out-of-hospital births.

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. Refer to OAR 410-130-0220 for medical and surgical services that are Not Covered/Bundled services.

(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, birth 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 based upon the Health Evidence Review Commission's (HERC) Prioritized List of Health Services Guideline Note 153;

(c) 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 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(s) for conditions described in Guideline Note 153 were not obtained or if the recommendations of the consulting provider are not adhered to by the out-of-hospital birth provider 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 (Medical Doctor/Doctor of Osteopathic Medicine or Certified Nurse Midwife) 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).

(d) 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.

(e) For out-of-hospital births, drugs authorized in subsection (d) 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.

(f) 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 kits;

(g) During labor, delivery support or the postpartum period in an out-of-hospital setting, should any of the conditions identified in Guideline Note 153 which require transfer develop, the Division requires that the client(s) be transferred to a hospital, and the Division may deny payment for labor, delivery support or postpartum 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;

(h) 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. Refer to the out-of-hospital birth provider guide for additional information. The Division may deny payment for services if appropriate risk assessments were not performed during labor, delivery or postpartum or when the appropriate consultation policies described in subsection (c) were not followed;
(i) 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;
(j) 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.
(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