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Introduction

This guide acts as the single source for Oregon Medicaid provider guidance related to provision of services under Medicaid during the COVID-19 emergency declaration, as supported by:

- Oregon Administrative Rule (OAR) 410-120-0011 (Effect of COVID-19 Emergency Authorities on Administrative Rules) and
- Flexibilities approved by the Centers for Medicare & Medicaid Services, described on OHA’s page about Temporary Waivers and Flexibilities for Medicaid Programs during the COVID-19 emergency.

The Oregon Health Authority (OHA) shall issue guidance concerning any OAR in the Medical Assistance Program rules (Chapter 410) that is inconsistent with the COVID-19 Emergency Authorities rule.

- Where information is contradictory, guidance issued by authority of OAR 410-120-0011 supersedes the Chapter 410 rules for the duration of the COVID-19 emergency declaration.
- Where applicable, this guide notes the rules that OAR 410-120-0011 supersedes.
- Any part of Chapter 410 rules not addressed in emergency guidance still applies.

If you have any questions about OHP coverage during the COVID-19 emergency, email covid.19@dhsoha.state.or.us.

Accessibility

Everyone has a right to know about and use OHA programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters,
- Written materials in other languages, Braille, large print, audio and other formats.

If you need help or have questions, please contact Mavel Morales at 1-844-882-7889, 711 TTY, or OHA.ADAModifications@dhsoha.state.or.us.

Other COVID-19 resources for providers

This guide only pertains to Medicaid coverage. For information about public health precautions, infection control guidance, Oregon’s vaccine distribution strategy, state guidelines for resuming elective and non-emergent services and other clinical information, please refer to the Public Health Division’s COVID-19 page for health care providers and partners.
Providing Culturally and Linguistically Appropriate Services

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards):

- Emphasize respectful, understandable, effective and equitable care, and
- Provide a framework for improving quality and eliminating health care disparities.

During the COVID-19 emergency, the importance of providing CLAS-based care is elevated because of the disproportionate impacts that COVID-19 infections and mortality have on the populations who rely most on CLAS-based care for quality, reliable, and meaningful access to services.

**OHA’s expectations for coordinated care organizations (CCOs) and providers**

OHA is committed to ensuring that its programs and activities comply with civil rights laws such as ORS 659A.403, Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act, as established in OHA’s [nondiscrimination policy and procedures for investigating reports of discrimination](#).

To reduce barriers to accessing quality and appropriate care for priority populations and advance Health Equity ([OHA’s Health Equity definition](#)), OHA expects all OHP-enrolled providers and CCOs to provide services in support of OHA’s health equity goals, consistent with National CLAS Standards. This means all health services, including telemedicine services:

- **Are culturally responsive**: Specifically, providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Providers must demonstrate awareness of, and sensitivity to, cultural differences and similarities, and the effect on the member’s care;
- **Provide meaningful access to language services** as required by [Title VI of the Civil Rights Act](#), the [Americans with Disabilities Act (ADA)](#), [Section 1557 of the Affordable Care Act](#) and corresponding regulations [45 CFR Part 92](#); and
- **Are provided in an equitable and inclusive manner**, without regard to race, color, religion, national origin, sex, age, disability, English proficiency, or economic status. See the U.S. Department of Health and Human Services (HHS) [Office of Civil Rights Action Bulletin](#).

CCOs are required to ensure all services are provided according to National CLAS Standards. OHA also requires CCOs to reimburse certified and qualified Health Care Interpreters (HCIs) for interpretation services provided via telemedicine at the same rate as face-to-face interpretation services. See OARs 410-141-3515(12) and 410-141-3860(12).
Providing culturally responsive care

A person- and family-centered approach to culturally responsive services begins with understanding the social and cultural differences among members, then providing care that is consistent with members’ social and cultural preferences. Culturally responsive services include:

- Working with OHA-approved HCIs, available on OHA’s HCI Registry;
- Working with Traditional Health Workers (THWs), available on OHA’s THW Registry; and
- Recognizing implicit bias in service delivery for patients or members, including individuals who have physical disabilities, who are Deaf or hard of hearing, or who have developmental or intellectual challenges; and delivering appropriate services in way that helps overcome any bias. Helpful resources on this topic include NW ADA Effective Communication, ARC Q and A on COVID-19 and Down Syndrome, National Association for the Deaf Guidance and Supporting Individuals with Autism.

Providing language access services

Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA), Section 1557 of the Affordable Care Act and corresponding regulations 45 CFR Part 92 (Section 1557) require CCOs and providers to ensure meaningful access to language services. These federal requirements are not waived during the COVID-19 emergency.

Providers and CCOs must ensure all services, including telehealth/telemedicine services preserve meaningful access to language services as described on the U.S. Department of Health and Human Services’ Office of Civil Rights website and in OHA’s questions and answers about language assistance services.

To learn more about preserving language access for telemedicine services, please refer to the Telehealth/Telemedicine section of this guide.

Examples of situations that may not be appropriate for a telehealth/telemedicine appointment include when:

- There is a need to discuss complex diagnoses or sensitive or emotionally charged topics;
- The patient has difficulty with using telemedicine technology; or
- The patient needs another person in the room to manage the technology.

In these cases, consider using in-person care and interpretation for such services, if personal protective equipment can be secured for HCIs and THWs involved to reduce health risk exposures.

Reimbursement

Fee-for-service (OHA)

From January 1, 2021, through June 30, 2021, OHA will pay an administrative add-on fee for interpreter services at fee-for-service (FFS) health care visits (including telehealth visits). The fee, as approved by the Centers for Medicare & Medicaid Services, is payable at a rate of $60 once per event. OHA will cover this fee only when:

- The fee is billed in conjunction with a covered OHP service or medically necessary follow-up visit(s) related to the initial covered service;
- The fee is not billed in conjunction with bundled rate services that incorporate administrative costs (e.g., inpatient hospital stays, home health or hospice visits, services provided by long-term care facilities, or services billed at an encounter rate by rural health clinics, federally qualified health centers and tribal health centers); and
- The language assistance service is provided by a qualified or certified HCI as described in ORS 413.
Providers remain responsible for ensuring interpreter services are provided to ensure effective communication and billing OHA for the service. Federal Medicaid requirements do not allow interpreters to enroll and bill as Medicaid providers.

**Keep documentation in the medical record** that indicates use of qualified or certified HCIs for any potential audit of services billed.

**CCOs**

The addition of this add-on fee for interpreter services at FFS health care visits does not change CCO requirements related to reimbursement of qualified and certified HCIs for interpretation services. See Oregon Administrative Rules 410-141-3515(12) and 410-141-3860(12) and OHA’s May 2020 memo about requirements to ensure culturally and linguistically appropriate care for OHP members.

## References

**Federal guidance**

- Title VI of the Civil Rights Act
- The Americans with Disabilities Act (ADA)
- Section 1557 of the Affordable Care Act and corresponding regulations 45 CFR Part 92 (Section 1557)
- HHS Office of Civil Rights Action Bulletin

**Oregon Administrative Rules**

- 410-141-3515(12) Network Adequacy
- 410-141-3860(12) Integration and Coordination of Care
- OAR Chapter 943 Division 5 OHA’s nondiscrimination policy and procedures for investigating reports of discrimination

**Previous guidance**

This section incorporates guidance in the following documents:

- Add-on fee for interpreter services now open for fee-for-service payment (12/31/2020)
- Providing culturally and linguistically appropriate services during the COVID-19 emergency (5/11/2020)
COVID-19 Services

This guidance applies to OHA’s fee-for-service (FFS) coverage of COVID-19 vaccine, testing, screening and treatment for Oregon Health Plan (OHP) and CAWEM members.

CAWEM recipients may obtain vaccines, tests and treatment at an emergency department, clinic, or urgent care that accepts open card (fee-for-service). To learn more, refer to the Medical Eligibility section of this guide.

OHP and CAWEM members may not be billed for any COVID-19-related services, including any administrative fees or cost-sharing.

To learn about coordinated care organization (CCO) coverage, please contact the CCO.

Vaccine administration

OHP covers the administration of COVID-19 vaccine supplied to providers through allocations from the federal government. This guidance includes FDA-approved Pfizer and Moderna vaccine. OHP will cover administration of additional products once they receive FDA approval.

Reimbursement

FFS program rates for the administration service are listed below. No payment will be made for the vaccine serum. Once the FDA approves single-dose vaccines, the rate for single-dose vaccines will be $28.39.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001A</td>
<td>Pfizer-Biontech Covid-19 Vaccine Administration – First Dose</td>
<td>$16.94</td>
</tr>
<tr>
<td>0002A</td>
<td>Pfizer-Biontech Covid-19 Vaccine Administration – Second Dose</td>
<td>$28.39</td>
</tr>
<tr>
<td>0011A</td>
<td>Moderna Covid-19 Vaccine Administration – First Dose</td>
<td>$16.94</td>
</tr>
<tr>
<td>0012A</td>
<td>Moderna Covid-19 Vaccine Administration – Second Dose</td>
<td>$28.39</td>
</tr>
</tbody>
</table>

Physical health and dental providers may bill OHA for FFS COVID-19 vaccine administration at these rates using the professional claim format. Pharmacies may bill in both the professional and pharmacy claim formats (including point of sale). See the Billing section of this guide to learn more.

OHA is working with the Centers for Medicare & Medicaid Services to determine the reimbursement rate for Federally Qualified Health Centers, Rural Health Clinics, Indian Health Service and Tribal 638 clinics for COVID-19 vaccine administration.

OHA is also in the process of finalizing payment arrangements for administration of COVID-19 vaccinations with its 15 contracted CCOs. Additional guidance to CCOs is forthcoming.
Medicaid provider enrollment

To receive payment providers must be OHP-enrolled; however, providers that are not currently enrolled with OHP should not delay administering vaccine to OHP members.

- OHP is working to make enrollment as streamlined as possible and will extend provider enrollment retroactively, if necessary, to cover prior dates of service.
- Unless there is evidence of a provider exclusion or license discipline, OHP will enroll all providers administering COVID-19 vaccine to OHP members.

To learn more about enrolling as an Oregon Medicaid provider, visit the OHP Provider Enrollment page.

Enrollment as an Oregon immunization provider

First, complete required ALERT IIS user and inventory training as described on OHA’s COVID-19 Training for Vaccine Providers page.

After that, log into OHA’s online registration system to register as a COVID-19 vaccine provider.

- Existing immunization providers will log in with their ALERT IIS Organization Code or Vaccines for Children (VFC) PIN.
- New providers will use the Alert IIS Organization Code issued by OHA following completion of required Alert IIS required training, user agreement and confidentiality forms.

“No Wrong Door” policy for providers serving FFS and CCO members

OHA has implemented this policy to ensure access for both FFS and CCO members when they present at any OHP-enrolled COVID-19 vaccine provider location to receive a COVID-19 vaccination.

- Providers contracted with the member’s CCO should bill the CCO.
- Providers not contracted with the member’s CCO should bill OHA. Be sure to also contact your local CCO(s) to explore direct contracting options.

For two-dose vaccines:

Before providing the first dose, instruct members to:

- Use the same provider for both vaccinations.
- Get the second dose on the date specified by the manufacturer’s product labeling.

Lab tests

OHP covers testing for COVID-19 as a diagnostic service. Tests used must have FDA Emergency Use Authorization (EUA) or FDA approval as outlined in OHA’s clinical guidance about COVID-19 testing.

Refer to OHA’s COVID-19 testing guidance for health care providers for recommendations of whom to test for COVID-19, how to prioritize testing when resources are scarce, and how to communicate testing results to patients.

Viral testing

Tests for current COVID-19 infection are covered for all OHP and CAWEM members, whether symptomatic or asymptomatic, when ordered by a qualified health care provider.

- OHP will rely upon the clinical judgment of the health care provider to determine medical necessity for viral testing.
- Providers should consider OHA’s COVID-19 testing guidance for health care providers when determining medical necessity.
Testing can be in traditional office locations as well as any “drive-through” or non-traditional locations.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0202U</td>
<td>Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected (effective for dates of service on or after 5/20/2020).</td>
</tr>
<tr>
<td>0223U</td>
<td>Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected (effective for dates of service on or after 6/25/2020).</td>
</tr>
<tr>
<td>0225U</td>
<td>Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected (effective for dates of service on or after 8/10/2020)</td>
</tr>
<tr>
<td>87426</td>
<td>Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19]). May be conducted as a rapid point of care test (effective for dates of service on or after 6/25/2020)</td>
</tr>
<tr>
<td>87635</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA): severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique.</td>
</tr>
<tr>
<td>87636</td>
<td>Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique (effective for dates of service on or after 10/06/2020)</td>
</tr>
<tr>
<td>87637</td>
<td>Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique (effective for dates of service on or after 10/06/2020)</td>
</tr>
<tr>
<td>87798</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism</td>
</tr>
<tr>
<td>87811</td>
<td>Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), effective for dates of service on or after 10/06/2020</td>
</tr>
<tr>
<td>U0001</td>
<td>CDC 2019 novel coronavirus (2019-nCoV) real-time RT-PCR diagnostic panel</td>
</tr>
<tr>
<td>U0002</td>
<td>2019-nCoV coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC.</td>
</tr>
<tr>
<td>U0003</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies.</td>
</tr>
<tr>
<td>U0004</td>
<td>2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies.</td>
</tr>
</tbody>
</table>

**Antibody tests**

COVID-19 antibody testing (also known as serology testing) to diagnose SARS-CoV-2 is covered only to evaluate a hospitalized person for possible multisystem inflammatory syndrome in children (MIS-C) or multisystem inflammatory syndrome in adults (MIS-A).

For antibody tests meeting OHA’s criteria, providers and CCOs may use the following codes for billing. These
codes are in the Diagnostic Procedures Group, paid at the indicated rates:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>86328</td>
<td>Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (e.g., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])</td>
<td>$45.23</td>
</tr>
<tr>
<td>86413</td>
<td>Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative (effective for dates of service on or after 9/08/2020)</td>
<td>$42.13</td>
</tr>
<tr>
<td>86769</td>
<td>Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])</td>
<td>$42.13</td>
</tr>
</tbody>
</table>

As evidence emerges about the utility of antibody/serology testing, the Health Evidence Review Commission (HERC) will continue to review research and technology advances before issuing formal coverage guidelines, if appropriate.

### Monoclonal antibody administration

OHP covers the infusion and monitoring service for administration of monoclonal antibody distributed through the HHS allocation to states. No payment will be made for drugs obtained at no cost through this allocation. Providers should check the member’s OHP enrollment and bill the appropriate CCO or OHA for these services.

### Other services

Please refer to HERC’s list of Novel Coronavirus Diagnosis and Procedure Codes.

### Hospital care

**Care provided in a tent outside the emergency department (ED)**

If services are provided in a tent located near the ED and the ED staff provides care, the tent will be considered an extension of the ED.

**Acute care hospitals**

If a Medicaid client is admitted as an inpatient for any of the reasons described below, OHA will pay hospitals the diagnosis-related group (DRG) rate and any cost outliers for the entire stay, including any quarantine time when the patient does not meet the need for acute inpatient care, until the patient is discharged.

**Transfers from long-term care (LTC) facilities for isolation/quarantine**

OHA will pay for the inpatient hospitalization of LTC resident moved to a hospital for medical reasons, even if the medical reason is to control the spread of infection of a communicable disease.

During this public health emergency, the medical reason does not have to be solely based on the acuity level of the resident, as long as the resident is being moved to a hospital under an order from a physician or other provider authorized to order such a move.

For hospital stays less than 48 hours the hospital can bill as an observation stay per OAR 410-125-0360(4); any stay that exceeds 48 hours must be billed as inpatient.
Delays in discharge of non-COVID patients to LTC facilities
If a patient is ready for discharge but their LTC facility isn’t accepting residents, the patient can remain in an inpatient setting for medically necessary care.

Billing for COVID-19 patients moved to a private room to avoid infecting other individuals
These patients may not meet the need for acute inpatient care any longer but may remain in the hospital for public health reasons. Hospitals having both private and semiprivate accommodations may not charge the patient a differential for a private room if the private room is medically necessary.

Federal reimbursement of COVID-19-related services for the uninsured
Providers who have conducted COVID-19 testing to uninsured individuals, provided treatment for uninsured individuals with a COVID-19 diagnosis on or after February 4, 2020, or administered COVID-19 vaccines to uninsured individuals can file claims with HHS for reimbursement.

Learn more on the federal Health Resources Services Administration website.

References

Health Evidence Review Commission
Novel Coronavirus Diagnosis and Procedure Codes

Federal guidance
The recent Centers for Disease Control Interim Guidelines for COVID-19 Antibody Testing state that until more information is available about the dynamics of IgA detection in serum, testing for IgA antibodies is not recommended. In addition, antibody tests should not be used to:

- Determine immune status in individuals until the presence, durability, and duration of immunity is established,
- Make decisions about grouping persons residing in or being admitted to congregate settings, such as schools, dormitories, or correctional facilities, or
- Make decisions about returning persons to the workplace.

Federal legislation
The Families First Coronavirus Response Act grants state Medicaid programs certain flexibilities in covering COVID-19 antibody testing. These flexibilities include:

- Using controls to ensure the clinically appropriate use of antibody/serology testing.
- Collecting tests at sites other than doctors’ offices or clinics (e.g., parking lots).

It also prohibits cost-sharing for any COVID-19-related services.

Previous guidance
This section incorporates guidance in the following documents:

- Oregon Health Plan coverage of COVID-19 antibody testing (10/23/2020)
- Oregon Health Plan coverage of COVID-19 testing (8/14/2020)
- Oregon Health Plan coverage of COVID-19 antibody testing (6/8/2020)
- Providing culturally and linguistically appropriate services during the COVID-19 emergency (5/11/2020)
Telehealth/Telemedicine Coverage

During these challenging times, OHA understands that access to telehealth/telemedicine for physical, oral and behavioral health care is necessary and encourages all OHP providers and plans to expand telehealth opportunities. This guidance is intended for:

- Physical health, behavioral health, and oral health care providers and billing staff
- CCOs
- Dental care organizations (DCOs)

OHA is reviewing ways to increase member access to emergent physical, behavioral and oral health services. OHA is requesting additional telehealth/telemedicine authority from CMS to assure continued access to services for covered members and will update this guide with any changes that allow additional services to be provided via telehealth/telemedicine.

For school-based health services (SBHS) provided to Medicaid-eligible children and students eligible for health-related services under the Individuals with Disabilities Education Act (IDEA), please refer to OHA’s guidance for SBHS providers.

If you have questions about OHA’s fee-for-service coverage of telehealth/telemedicine services, contact Provider Services (800-336-6016).

If you have questions about CCO/DCO coverage of telehealth/telemedicine services, contact the CCO or DCO.

Reimbursement

Fee-for-service (OHA)
Covers telehealth/telemedicine/teledentistry services retroactive to January 1, 2020. Reimbursement is the same as reimbursement for in-person services.

Coordinated care organizations (CCOs)
CCOs are required to cover telehealth/telemedicine services effective March 13, 2020, but OHA has encouraged CCOs to make this coverage retroactive to January 1, 2020.

- Contact the patient’s CCO for specific guidance on their telehealth/telemedicine coverage and reimbursement policies.
- CCO contracts require CCOs to ensure that telehealth/telemedicine credentialing requirements are consistent with OAR 410-130-0610(8).

CCOs may issue their own requirements about referrals for services. Refer to each payer’s billing guidance.
CCO telehealth/telemedicine pay parity requirements for providers during the COVID-19 emergency

OAR 410-141-3566 Telemedicine Payment Parity Requirements requires CCOs to ensure payment parity for providers practicing telehealth/telemedicine.

This means CCOs must ensure that telehealth/telemedicine reimbursement is the same as reimbursement for in-person services.

Health-related services (HRS)

HRS are services that are not covered benefits under Oregon’s Medicaid State Plan, that CCOs may provide their members if the services are not otherwise administratively required and are intended to improve care delivery and overall member and community health and well-being.

- The cost of telephone equipment and telephone or internet service plans necessary for members to receive services via telehealth/telemedicine are considered HRS.
- Providers are encouraged to contact CCOs to request HRS funding for phone services when necessary.

More information about HRS is available on OHA’s Health-Related Services page.

Covered services

To ensure OHP members have continued access to appropriate physical, behavioral and oral health services during the COVID-19 pandemic, OHA is expanding coverage for the delivery of services using telehealth/telemedicine and telephone platforms.

Guideline Note A5 (Telehealth, Teleconsultations and Online/Telephonic Services) lists the covered services.

- Health care providers may provide and bill OHA or the patient’s CCO for medically necessary and appropriate covered services provided through telehealth/telemedicine. Services performed must be within the licensed health care provider’s scope of practice as governed by their licensing board and, as applicable, behavioral health provider qualifications described in OAR 309-019-0125.
- Telehealth/telemedicine visits are encouraged for all services that can reasonably approximate an in-person visit, not just those relating to a COVID-19 diagnosis.
- Certain service code descriptions specify they are only for established patients. During the COVID-19 emergency, OHA encourages providers (and CCOs) to provide telehealth/telemedicine services (including telephone services) to new patients. OHA will not be auditing to confirm established patient status for these telephone/online codes during the COVID-19 emergency.
- OHA-enrolled providers may provide telehealth/telemedicine services from a clinic, office, home or other setting which supports a private interaction.
- Patients may receive services from their home, day treatment setting, or where they are physically located if telehealth/telemedicine services are appropriate.

OHA received federal authority to allow out-of-state providers to conduct telehealth/telemedicine services for Oregon patients. However, OHA is unable to speak to whether other states permit Oregon-licensed practitioners to practice in their state.

Oregonians who move out-of-state due to the COVID-19 emergency may continue to receive services, as long as they are OHP recipients. Oregonians who are temporarily placed in an out-of-state facility may also continue to receive services.
Provider-patient services
Providers may bill in-person CPT or HCPCS codes for any service that is ordinarily covered and for which the provider believes the clinical value reasonably approximates the clinical value of an in-person service. For example:
- Office visits, physical and occupational therapies, preventive medicine, psychotherapy
- CPT codes 99201-99205, 99211-99215, 99495-99496 for ordinary office visits via synchronous audio/video (telephone acceptable during COVID-19 emergency if A/V not available or feasible)

See CMS’s Telehealth Codes for a list of procedure codes covered by Medicare. OHP will cover additional codes meeting criteria described in HERC Guideline Note A5.

Telehealth/telemedicine services
OHA encourages the delivery of medically necessary and appropriate physical, behavioral and oral health services through live audio and video interaction between the patient and their health care provider whenever possible.
- Telephone (audio only) or electronic communications (patient portal) may be used to remove barriers such as a patient not having access to a computer with internet access or video capability.
- Providers may be reimbursed at the in-person rate for using telephone communications when barriers to equipment and access exist. In some cases, specific modifiers or place of service codes are needed to specify the service was delivered by telehealth/telemedicine (see guidance below).
- Members can receive telehealth/telemedicine services in locations chosen by them, including their home.

Telephone and online services
Providers may only bill for telephone and online services once per 7 days. Coverage does not include:
- Telephone calls without medical decision making
- Chart reviews
- Electronic mail messages
- Images transmitted via facsimile machines or electronic mail
- Prescription renewal
- Scheduling tests
- Reporting normal test results
- Requesting a referral

Providers can bill services for new and established patients, even if the codes specify “existing patients.”

Telephone calls can be billed for the following services:
- **Evaluation/Management (E/M):** 99441-99443 for providers who can provide evaluation and management services, such as physicians, physician assistants or nurse practitioners;
- **Assessment/Management (A/M):** 98966-98968 for providers who cannot bill E/M, including nonphysician behavioral health providers and dietitians

Online services (e.g., patient portal) can be billed for the following services:
- **Evaluation/Management (E/M):** 99421-99423 for providers who can provide evaluation and management services, such as physicians, physician assistants or nurse practitioners;
- **Assessment/Management (A/M):** G0270-G0272 for providers who cannot bill E/M, including nonphysician behavioral health providers and dietitians
Telephone and online codes are eligible for payment when the service is:

- Initiated by the patient (providers can make patients aware of offering and place the call);
- Provided by a qualified professional to a patient, parent, or guardian;
- Not related to an E/M or A/M service provided within the previous 7 days; and
- Not related to an E/M or A/M service scheduled to occur within the next 24 hours or soonest available appointment.

**Coding chart for telephone and online/digital (e.g., asynchronous patient portal) services**

Select the appropriate E/M code based on the time spent in health care decision making (not the total encounter time).

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Telephone</th>
<th>Online/digital</th>
</tr>
</thead>
<tbody>
<tr>
<td>E/M by a qualified physician:</td>
<td>99441: 5-10 minutes of discussion</td>
<td>99421-99423</td>
</tr>
<tr>
<td>MD, DO, naturopathic doctor</td>
<td>99442: 11-20 minutes of discussion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99443: 21-30 minutes of discussion</td>
<td></td>
</tr>
<tr>
<td>E/M by a qualified nonphysician:</td>
<td>99441: 5-10 minutes of discussion</td>
<td>98970-98972</td>
</tr>
<tr>
<td>Nurse practitioner, physician assistant, acupuncturist)</td>
<td>99442: 11-20 minutes of discussion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99443: 21-30 minutes of medical discussion</td>
<td></td>
</tr>
<tr>
<td>E/M by a qualified nonphysician:</td>
<td>98966: 5-10 minutes of discussion</td>
<td>G2061-G2063</td>
</tr>
<tr>
<td>Any type not able to bill E/M (e.g., RN, physical therapist, speech therapist,</td>
<td>98967: 11-20 minutes of discussion</td>
<td></td>
</tr>
<tr>
<td>counselor, social worker)</td>
<td>98968: 21-30 minutes of discussion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G2061-G2063</td>
<td></td>
</tr>
</tbody>
</table>

**Quick check-ins**

5-10 minute check-in via telephone, audio or audio/visual modality can be billed using the following code.

- G2012: Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services

For communication outside of a patient portal or EHR, text messages or email may billed as a quick check-in only if the text/email platform meets HIPAA security requirements. However, most commonly available text messaging and email services are not HIPAA-compliant. These services were not identified as acceptable media in the [HHS notice of enforcement discretion related to telehealth/telemedicine](https://www.hhs.gov/). 

**Telehealth/telemedicine visits related to home blood pressure monitoring**

Providers may bill for visits related to education, monitoring and consultation using the following codes:

- 99473: Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
- 99474: Separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient

Practices should designate appropriate staff to ensure proper cuff fit, provide patient education on how to take an accurate blood pressure, give patients instruction on blood pressure monitoring, have a system to check-in with patients about their blood pressure, and establish protocol to determine when a patient must be seen in-person (at the office or hospital) for further assessment.
Provider consultations

Consultations must comply with criteria outlined in HERC Guideline Note A5 and CPT coding standards.

- **Consulting Providers:** Use CPT 99451, 99446-99449
- **Requesting Providers:** Use CPT 99452

Limited information provided by one clinician to another that does not contribute to collaboration (e.g., interpretation of an electroencephalogram, report on an x-ray or scan, or reporting the results of a diagnostic test) is **not** considered a consultation.

Online platforms may be used for provider-to-provider consultation as long as they comply with HIPAA privacy standards.

Coverage criteria

To be eligible for coverage, telehealth/telemedicine services must comply with the following criteria, in addition to any program-specific requirements listed below.

- OAR 410-120-1200 (excluded services and limitations),
- OAR 410-130-0610 (Telemedicine),
- Guideline Note A5 (Telehealth, Teleconsultations and Online/Telephonic Services) from the Prioritized List of Health Services.

Physical health services

**Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)**

Telehealth/telemedicine services may be utilized by physicians for face-to-face encounters for prescribing DME and medical supplies. Physical therapists, occupational therapists, and speech therapists may use telehealth/telemedicine while providing evaluations and assessments for DME, when clinically appropriate.

Providers should follow the telehealth/telemedicine policies for their services as described in this guide.

**Custom wheelchairs**

When clinically appropriate, the Assistive Technology Professional (ATP) may conduct evaluation and home assessment through HIPAA-compliant, interactive, real-time audio and video telemedicine platforms. Services of the ATP, whether in-person or remotely, are not separately payable.

**Home blood pressure monitoring supplies**

OHP will cover the following supplies in conjunction with telehealth/telemedicine visits.

- A4760: Standard blood pressure cuffs
- A4670: Automatic blood pressure cuffs

For both fee-for-service and CCO members, blood pressure cuffs are covered without prior authorization under OARs 410-122-0620 (Miscellaneous Supplies) and 410-141-3501 (CCO Rule Order of Precedence) if medically appropriate for an above-the-line diagnosis on the Prioritized List of Health Services.

Although the individual must have an above-the-line diagnosis, a pre-existing diagnosis of hypertension is not required to qualify for a blood pressure cuff.

For fee-for-service members, the prescription must be filled by an OHP-enrolled durable medical equipment (DME) supplier. The supplier will need the prescription and a visit note documenting the medical need (the visit can be a telehealth/telemedicine visit).
Delivery
Custom wheelchairs and other complex rehabilitation equipment must be delivered in person, by the ATP, to ensure proper fit and necessary adjustments are made for the client to safely operate the equipment.

For proof of delivery
No signature will be required by the client or client’s representative when a delivery is received. However, the person delivering the supplies should document the date and time of delivery for the vendor’s records.

CPAP face-to-face visit following 3-month trial
The required follow up visit with the prescriber of the CPAP may be waived or conducted via telehealth/telemedicine.

Physical, occupational and speech therapy services
OHP will reimburse for the following therapy codes when provided through a telehealth/telemedicine modality:

- 97161-97168, 97110, 97112, 97116, 97535, 97550, 97760, 97761, 92521-92524, 92507
- Telephone/online codes: G2061, G2062, G2063, G2010, G2012, 98966, 98967, and 98968

The maximum allowable units have not changed. See OARs 410-131-0040(7) (PT/ OT rule), and 410-129-0075 (Speech Language Pathology) for program-specific requirements.

If you do not have a synchronous audio/visual telehealth/telemedicine platform to perform face-to-face visits for initial assessments and/or re-evaluations, you must ask OHA for approval to conduct them by phone.

- To do this, submit a prior authorization request to OHA. Your supporting documentation must include a letter describing the barriers and how you will accomplish the assessment.
- Other services conducted by phone do not require prior authorization during the COVID-19 emergency.

Visual services
OHA revised OAR 410-140-0020 to allow visual service providers (optometrists, ophthalmologists and opticians) to use telehealth/telemedicine for services that are not required to be provided face-to-face in an in-person setting.

To use telehealth/telemedicine for services that require a face-to-face setting when there is a documented barrier to providing in-person services, providers must request prior authorization.

Providers may provide covered services within their licensure via telehealth/telemedicine to OHP members living out-of-state as long as the initial in-person visit has been met.

Well-child visits
Well-child visits meeting the criteria in HERC Guideline Note A5 are covered via telehealth/telemedicine. Most notably:

- The clinical value of the service provided must reasonably approximate the value of an in-person service.
- For example, if the purpose of the visit can be achieved without a physical examination and any required immunizations are billed separately (e.g., provided in a “drive-by” service), then it would be covered.

Oral health services
The Dental Services rule about teledentistry (OAR 410-123-1265) has not changed. OHA is expanding accepted modalities during the COVID-19 emergency as permitted by Guideline Note A5, revisions to the main telehealth/telemedicine rule (410-130-0610) and as described above.
This includes accepting audio-only (e.g., telephone) services as an accepted teledentistry delivery method during the COVID-19 emergency.

Behavioral health services

The fee-for service behavioral health fee schedule lists the codes that may be billed.

- These codes list “GT” in the “Allowed modifiers” column on the Mental Health, Substance Abuse Disorder, and Peer Delivered Services tabs of the fee schedule.
- OHA is also adding the GT modifier to the following codes: H0004, H0005, H0006, H0015, T1006 and 90849.
- If a code does not have GT listed as an allowable modifier, it is not open for telehealth/telemedicine.

1915(i) Home and Community-Based Services (HCBS) State Plan Option

20-0011 Temporary Changes to 1915(i) HCBS State Plan Option, effective 3/1/2020, allows:

- Needs assessments to be completed by communication methods such as telehealth/telemedicine in lieu of face to face visits and in accordance with HIPAA, as directed by OHA.
- Person-centered service plan (PSCP) development and completion by communication methods such as telehealth/telemedicine, in lieu of face-to-face visits and in accordance with HIPAA, as directed by OHA.
- Home-Based Habilitation, HCBS Behavioral Habilitation, and Psychosocial Rehabilitation Services to be provided via telehealth/telemedicine, in lieu of face-to-face visits and in accordance with HIPAA, as directed by OHA.
- Oral approval of individuals, guardians, and providers on person-centered service plans (must obtain written signature at a later time).
- Provision of HCBS by providers when individuals are hospitalized. These services cannot duplicate what the hospital is required to provide. These HCBS are focused on personal, behavioral and communication support and cannot exceed 30 days.

Applied Behavior Analysis (ABA)

During the Public Health Emergency, OHA will open ABA assessment codes for reimbursement through telehealth/telemedicine using the “GT” modifier as identified in the “Allowed Modifiers” column in the behavioral health fee schedule.

- 97151: Behavior identification assessment and plan of care; can be completed by the following rendering providers:
  - Board Certified Behavior Analyst (BCBA);
  - Physician;
  - Psychologist;
  - Legislatively approved licensed healthcare professional

- 97152: Behavior identification-supporting assessment, administered by one technician; can be completed by the following rendering providers:
  - Board Certified Behavior Analyst (BCBA);
  - Board Certified Assistant Behavior Analyst (BCaBA)
  - Registered Behavior Analysis Interventionist (BAI)
  - Physician;
  - Psychologist;
  - Legislatively approved licensed healthcare professional

Behavior rehabilitation services

OAR 410-170-0080(4) permits behavior rehabilitation service (BRS) providers and contractors to provide services via telehealth/telemedicine when in-person, face-to-face settings are not required.
The Oregon Department of Human Services (ODHS) and Oregon Youth Authority are responsible for determining when to permit telehealth/telemedicine delivery of BRS services and communicating the specific requirements to their contractors.

**Psychotherapy and testing for agency-requested administrative examinations and reports**

OHP will reimburse for the following therapy and testing codes when provided through a telehealth/telemedicine modality to complete administrative exams and reports requested by approved state agencies using the OHP 729 form:

- 90785, 90791, 90792
- 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137
- 90889 and H1011

See OAR 410-150-0040(8) for the program-specific requirements.

**Skill reintegration (skill building) services**

Effective March 1, 2020, OHA will reimburse Medicaid behavioral health providers for skill reintegration (skill building) services delivered via telehealth/telemedicine using the following codes:

- H0036: Community psychiatric support and treatment
- H0046: Behavioral habilitation and home-based habilitation
- H2014: Skills training and development
- H2018: Psychosocial rehabilitation

Additionally, OHA will reimburse Medicaid behavioral health providers for G2012 (brief communication technology-based service) during the COVID-19 emergency.

**Traditional health workers**

Traditional health workers (THWs) can conduct telehealth/telemedicine visits.

- Rendering provider types are identified on the “MH Outpatient Services” tab in the Behavioral Health Fee Schedule.
- All codes for Peer Support Services have been opened to telehealth/telemedicine.
- THWs employed by a Certified Substance Use Disorder (SUD) program can provide telehealth/telemedicine under the direction of the SUD program, so long as the service is appropriate to be provided by a THW.

**Pre-Admission Screening and Annual Resident Review (PASRR) Level II Assessments**

PASRR Level II (SMI) contractors and clinicians may resume evaluations for nursing facility residents effective May 7, 2020, as long as the evaluations are conducted using a covered telehealth/telemedicine platform.

- Indicate in the body of the evaluation narrative that this evaluation was completed using telehealth/telemedicine such as a digital platform, phone or a tablet.
- Billing codes and the e-invoicing process remain unchanged.

**Federally qualified health centers, rural health clinics and Indian Health Service/Tribal 638 providers**

**Encounter rate for telephone and telehealth/telemedicine services**

OARs 410-146-0085 and 410-147-0120 now allow IHS/Tribal providers, FQHCs and RHCs to provide more telehealth/telemedicine services. The revisions:

- Expand the definition of a face-to-face encounter to include synchronous two-way audiovisual links between a patient and a provider, and
- Allow telephone encounters for evaluation and management services, assessment and management services, and psychotherapy during an epidemic of an infectious disease.
Encounters that are not excluded from the Prospective Payment System (PPS) or IHS Memorandum of Understanding (MOU) will be reimbursed at the clinic’s PPS/IHS encounter rate and will be eligible for wraparound payment.

Services excluded from the PPS or MOU have not changed and will not be reimbursed at the PPS/IHS rate (for example, incident-to, lab and radiology, and other items excluded in the FQHC/RHC rules).

If a service/code is reimbursable at the PPS/IHS encounter rate and delivered via telehealth/telemedicine, it may be reported for the wraparound payment.

**Establishing visits for APCM clinics**

Clinics that participate in OHA’s APCM program can establish a patient by telephone during the COVID-19 emergency. This means APCM clinics can:

- Add new patients, established during a telephone visit, to their patient list and
- Receive per-member per-month (PMPM) payments for these patients.

The definition of an APCM establishing visit will not change; only the face-to-face requirement is waived during the COVID-19 pandemic.

**Information security and privacy requirements**

**Permitted telemedicine/telehealth modalities during the COVID-19 emergency:**

To ensure continued access to services for covered members, certain telemedicine/telehealth modality requirements for encryption will not be enforced by federal authorities (or required by OHA) during the COVID-19 emergency.

- This means services such as FaceTime, Skype or Google Hangouts can be used for service delivery.
- HIPAA-compliant platforms are preferred when available.
- To learn more about the HIPAA enforcement discretion, visit the [Office of Health and Human Services website](https://www.hhs.gov).  

To the extent possible during the COVID-19 emergency, use telemedicine/telehealth platforms that comply with:

- [HIPAA privacy and security standards](https://www.hhs.gov)
- OHA’s Privacy and Confidentiality Rules ([Chapter 943 Division 14](https://www.leg.state.or.us/arc/174/Chap943_supp14.pdf))

**Confidentiality, privacy and security requirements**

Services must continue to comply with applicable privacy rules and security protections required by HIPAA for the protection of patients’ personal health information (PHI). Current enforcement discretions and guidance for protecting PHI during the COVID-19 emergency is available on the federal [Office of Civil Rights HIPAA and COVID-19 page](https://www.hhs.gov). For 42 CFR Part 2 (substance use disorder), see [guidance from the Substance Abuse and Mental Health Services Administration](https://www.samhsa.gov).  

Have policies and procedures in place to prevent a breach in privacy or exposure of protected health information or records (whether oral or recorded in any form or medium) to unauthorized individuals.

Have consent on file obtained from the patient or parent/guardian to receive services via telehealth/telemedicine prior to the initiation of telehealth/telemedicine services.

- Verbal consent to receive services is acceptable during COVID-19 emergency, but written consent is advisable. You can mail consent documents with a SASE or obtain written consent using patient portals
Consent to disclose substance use disorder treatment records protected by 42 CFR 2 must include the patient’s signature (to be obtained in-person, via mail, or electronically).

**Language access requirements**

As with in-person services, providers must ensure meaningful access to language services as required by Americans with Disabilities Act, Title VI of the Civil Rights Act, Section 1557 of the Affordable Care Act and corresponding federal law at 45 CFR Part 92 (Section 1557). This includes but is not limited to:

- American Sign Language interpretation services to individuals who are Deaf or Hard of Hearing and
- Spoken language interpretation services for individuals with limited English proficiency (LEP).

Interpreter services must be free, timely and protect the privacy and independence of the LEP individual. The interpreter must be a certified or qualified health care interpreter (HCI). This can be:

- An interpreter on OHA’s current HCI registry or
- Any other interpreter that meets the qualifications required by state and federal law.

You can ensure that telehealth/telemedicine modalities preserve the quality of interpretation services by:

- Working with qualified and certified health care interpreters
- Adhering to standard practices for choosing and working with telephonic interpreters
- Verifying that the quality for all video remote interpretation services comply with ASL VRI requirements

**Applying CLAS standards to telehealth/telemedicine services**

Providers and CCOs must ensure telehealth/telemedicine services:

- Are inclusive, accessible, and promote Health Equity;
- Are delivered through high-quality, accessible modalities that meet ADA and LEP requirements;
- Preserve the privacy and confidentiality of patient information, as outlined in the Office of Civil Rights Telehealth FAQ;
- Do not result in vicarious trauma or retraumatizing individuals (for example, requiring a patient to repeat difficult scenarios unnecessarily to an interpreter or provider); and
- Are appropriate for sharing remotely and/or through a third party.

**For more information:**

Please refer to the following resources to learn more about providing language access services.

- The federal Office of Civil Rights website
- OHA’s questions and answers about language assistance services

**Documentation**

Use same level of documentation as an in-person visit (e.g., SOAP charting). Documentation should follow standard billing requirements. In addition:

- Patient consent to receive services using a telehealth/telemedicine platform must be obtained and documented in the medical record prior to providing services.
- Noting telehealth/telemedicine delivery due to federal and state directives to practice physical distancing is advisable.
- For telehealth/telemedicine services not delivered via synchronous audio-video (A/V), note in the
patient’s record the reason A/V is not feasible.

References

Department of Consumer and Business Services (DCBS) and OHA
DCBS-OHA telehealth guidance

Health Evidence Review Commission
Ancillary Guideline Note A5 (Telehealth, Teleconsultations and Online/Telephonic Services) from the Prioritized List of Health Services.

Oregon Administrative Rules
410-120-1200 Excluded Services and Limitations
410-129-0095 Speech-Hearing
410-130-0610 Telemedicine
410-133-0040 Physical and Occupational Therapy
410-133-0040, 410-133-0080, 410-133-0220, 410-133-0245 School-based health services
410-140-0020 Visual Services
410-141-3830 Prioritized List of Health Services
410-146-0085 Indian Health Service and Tribal 638 clinics
410-147-0120 Federally Qualified Health Centers and Rural Health Clinics
410-150-0040 Administrative Reports and Examinations
410-170-0080 Behavior Rehabilitation Services
410-172-0850 Telemedicine for behavioral health

Federal legislation

The 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act (HR748) expands definition of telehealth/telemedicine service providers.

Previous guidance
This section incorporates and supersedes coverage, security, privacy, language access and documentation guidance in the following documents:
- OHP coverage of home blood pressure monitoring services during the COVID-19 emergency (9/3/2020)
- Providing culturally and linguistically appropriate services during the COVID-19 emergency (5/11/2020)
- Questions and answers from April 17 webinar (5/8/2020)
- Coverage of skill reintegration services delivered via telemedicine during the COVID-19 emergency (4/23/2020)
- Telehealth coverage of physical, occupational and speech therapy services during the COVID-19 emergency (4/21/2020)
- OHA Telemedicine Webinar (4/17/2020)
- Expanded teledentistry coverage during the COVID-19 emergency (4/16/2020)
- Audio-only teledentistry services are also covered during the COVID-19 emergency (4/7/2020)
- OHA Telemedicine Webinar (4/6/2020)
- Telemedicine-telehealth billing guidance for Oregon Health Plan fee-for-service providers (4/6/2020)
- APCM establishing visits via telephone are permitted starting March 23, 2020 (4/3/2020)
- Expansion of fee-for-service telemedicine coverage (3/23/2020)
- Expanded telehealth coverage for behavioral health services (3/20/2020)
- Oregon Health Plan coverage of telemedicine services (3/13/2020)
Medical Transportation

This guidance is for partners who provide or approve medical transportation for OHP members, including:
- Fee-for-service transportation providers
- Coordinated care organizations (CCOs)
- Non-emergent medical transportation brokerages

Ambulance services

Temporary rate increase for “Treat in Place” (Aid Call) services
Because “Treat in Place” calls can use the same amount of resources to transport crew, equipment, medications, Personal Protective Equipment, and other expenses, both OHA and CCOs will reimburse for procedure code A0998 (Aid Call) at ALS1 Base Rate during the COVID-19 emergency.

Fee-for-service rate
This increases the rate for procedure code A0998 from $54.45 to $420.62 (OHA’s ALS1 Base Rate for procedure code A0427).

Services for members enrolled in CCOs
OHA is not directing CCOs to align their reimbursement rates with fee-for-service rates, only to increase their Aid Call rate for A0998 to match their ALS1 Base Rate for A0427.

Ambulance transports for COVID-19 positive or presumptive positive OHP members
Ambulances may be used as non-emergent transportation for patients with a positive or presumptive positive COVID-19 diagnosis who need to access primary care, urgent care, or other non-hospital levels of care. These trips can follow the same protocols as a hospital run (e.g., advance notice of arrival).

Non-emergent medical transportation

Non-emergency medical transportation (NEMT) providers play a vital role in transporting vulnerable populations to medical treatment. NEMT providers shall provide safe and effective transportation to OHP members to ensure participation in the members’ covered services.

COVID-19 creates new risks for NEMT providers and the members they serve. As such, NEMT brokerages, providers (subcontractors and drivers) and CCOs should follow this written guidance and ensure their OHP members receive access to NEMT services as outlined in this document and in accordance with OARs 410-141-3920 and 410-136-3020.
OHP coverage of NEMT to alternate sites for COVID-19 vaccine administration

**Oregon's 1135 waiver** allows provision of Medicaid-covered services at alternate sites during the COVID-19 public health emergency. This includes rides to COVID-19 vaccination clinics set up at non-facility locations.

CCOs, brokerages, and NEMT providers must ensure that:

- OHP members can use NEMT to travel to the nearest local COVID-19 vaccination clinic, including clinics set up at alternate sites, to receive a COVID-19 vaccination; and
- For audit purposes, records on file with the CCO, brokerage or NEMT provider document the following:
  - The trip was for the member to receive a COVID-19 vaccination, and
  - The location of the vaccination clinic where the member received the service.

**NEMT stretcher van transports**

OHA will allow stretcher vans to provide ground NEMT that ambulance services would normally provide during the COVID-19 Public Health Emergency, unless the ordering provider/discharging facility deems ambulance service medically necessary for patient safety.

While the decisions regarding medical necessity and appropriate use of limited EMS resources lie ultimately with the discharging facility, patient safety remains the top priority.

- Please evaluate each case on a situational basis under sections (1) and (3) of OARs 410-141-3945: Transportation - Ground and Air Ambulance Transports (for CCO members) and 410-136-3160: Ground and Air Ambulance Transports (for fee-for-service members). Note that use of stretcher cars is consistent with rules regarding NEMT, found in OAR 410-136.
- Work with your local brokerages to arrange for appropriate modes of transport.

**Service delivery**

This replaces guidance issued on April 20, 2020 (“COVID-19 Guidance for NEMT”) and clarifies the responsibilities of brokerages and providers to ensure members arrive on time for covered services, using traditional NEMT services or non-emergency ambulance (NEA) services, as appropriate.

**Screen members for COVID-19 when they call to schedule transportation**

Brokerages may modify scripts for their call center representatives to address COVID-related concerns when scheduling transportation.

If a member provides information during the screening that raises safety concerns for the NEMT provider, NEA transport may be needed. The brokerage may escalate transport to a NEA transport, if needed, to ensure the member receives safe and timely transportation to their covered service.

**Alternate arrangements to ensure safety of NEMT providers and members**

If a member has concerns about safety due to vehicle conditions or a provider’s symptoms they and the provider should contact the CCO or NEMT brokerage to make alternate arrangements. If a NEMT brokerage is contacted by a member with concerns about their safety regarding the vehicle or provider, the brokerage is responsible for making alternate arrangements to transport the member.

If a provider has safety concerns about a member’s symptoms, the provider and NEMT brokerage must ensure other transportation is scheduled, including NEA. OHA expects all members to receive timely transportation to their appointments.

**Brokerage responsibilities before transporting COVID-19 positive or positive-presumptive members**

The brokerage shall:

- Notify the receiving health care facility that the member has symptoms suggestive of COVID-19 or is
COVID-positive, so appropriate infection control precautions may be taken before patient arrival; and

- Authorize NEMT if the service is safe and effective for the provider and member; or
- Authorize medically necessary NEA transports.
  
  - Fee-for-service transportation brokerages and CCOs may authorize NEA transport for members who present with symptoms of COVID-19, are suspected COVID-19 cases or are confirmed COVID-19 cases, if they cannot safely transport individuals using NEMT.

Brokerages are expected to follow the general responsibilities required for CCO members in OAR 410-141-3920 and for fee-for-service members in OAR 410-136-3020 including referring members to emergency transportation resources.

If NEA availability is limited, the brokerage is required to use their resources to meet the transportation needs of the passenger. If NEMT brokerages anticipate not being able to meet the needs of their passengers, they should notify OHA immediately at COVID.19@dhsoha.state.or.us.

**Billing for fee-for-service NEA transports**

Use procedure code A0998. Request authorization to bill using this code by submitting the OHP 405T form to OHA.

If a brokerage has any questions about existing responsibilities, please email COVID.19@dhsoha.state.or.us.

**Expired Oregon DMV-issued driver licenses and vehicle registrations for NEMT drivers**

According to current guidance from the Oregon Department of Motor Vehicles (DMV), CCOs, brokerages, and NEMT providers may allow drivers with expired Oregon driver licenses or vehicle registrations to serve eligible OHP members if:

- Their license or registration expired between Nov. 1, 2020, and April 30, 2021; and
- The license or registration has been expired for three months or less.

A three-month grace period will apply for these drivers while they wait for their appointment with DMV.

This flexibility does not:

- Alter other requirements that apply to NEMT providers, including training, insurance, criminal background checks, credentialing, incident reporting, safety equipment, and accessibility; or
- Apply to DMV licenses and registrations that are invalid for other reasons, such as motor vehicle violations.

**Documentation and renewal requirements**

OAR 410-141-3925(4)(a) and Exhibit B, Part 2, Section 5 g. (2)(d).i. of the 2021 CCO contract require CCOs to ensure each driver has a valid license. The contract also requires NEMT providers to document each driver’s current vehicle registration. OAR 410-136-3040(4)(a) requires brokerages to also ensure each subcontracted driver has a valid license.

To meet OAR and contract requirements, CCOs, brokerages, and NEMT providers must ensure:

- Drivers renew their driver licenses and vehicle registrations before the grace period expires;
- Drivers do not serve eligible OHP members if their driver license or vehicle registration has been expired for more than three months; and
- Records on file with the CCO, brokerage or NEMT provider document each driver allowed to serve eligible OHP members with an expired driver license or vehicle registration during the grace period.

Please refer to the Oregon DMV’s COVID-19 web page for information about the law enforcement moratorium (or “grace period”).
Federal guidance

CMS Approval of Oregon’s 1135 Waiver Request to Permit Service Delivery at Alternate Sites (3/26/2020)

The federal 1135 blanket waiver permits non-hospital buildings/space to be used for patient care and allows Critical Access Hospitals flexibility in establishing temporary off-site locations.

Oregon Administrative Rules

OAR 410-136-3020 General Requirements for NEMT
OAR 410-136-3040 Vehicle Equipment and Subcontractor Standards
OAR 410-136-3160 Ground and Air Ambulance Transports
OAR 410-136-3300 Reports and Documentation
OAR 410-136-3320 Audits
OAR 410-141-3520 Record Keeping and Use of Health Information Technology
OAR 410-141-3920 Transportation: NEMT General Requirements
OAR 410-141-3925 Transportation: Vehicle Equipment and Driver Standards
OAR 410-141-3945 Transportation - Ground and Air Ambulance Transports

Previous guidance

This section incorporates and supersedes the following guidance:

- OHP coverage of NEMT to alternate sites for COVID-19 vaccine administration (1/15/2021)
- Current NEMT requirements for expired licenses and vehicle registrations during COVID-19 (1/15/2021)
- NEMT stretcher van transports during the COVID-19 emergency (12/14/2020)
- Expired Oregon DMV credentials for NEMT drivers (7/9/2020)
- NEMT COVID-19 Guidance (4/20/2020)
- Ambulance transport and reimbursement policies during the COVID-19 emergency (4/14/2020)
- Brokerage Responsibility for Approving Non-Ambulance Transports (4/7/2020)

Rules superseded by OAR 410-120-0011 during the COVID-19 emergency

No NEMT rules are superseded by OAR 410-120-011 during the COVID-19 emergency.
Medical Eligibility

Oregon Health Plan eligibility during the COVID-19 emergency

Starting March 18, 2020, if a member has Oregon Health Plan (BMH, BMD, BMM, CWX) coverage, they will continue to be covered. This includes members who were scheduled for benefit closure due to redeterminations.

Even if an OHP member gets a letter that says their OHP is closing or they no longer qualify, OHP will not end their coverage. There are, however, a small number of reasons why coverage would be closed during this crisis. Please see the list of eligibility scenarios below for more information.

Eligibility will end only for members who:

- Become deceased;
- Become incarcerated. Benefits will be suspended while incarcerated;
- Ask for their coverage to end; or
- Are confirmed to have moved out of state for a reason that is not related to the COVID-19 emergency.

Eligibility will continue for all other members.

Examples of termination reasons that will not result in termination during the COVID-19 emergency include:

- Reported changes that would normally result in ineligibility, such as an increase in income;
- Women who qualified for OHP due to pregnancy and have reached the end of the 60-day post-partum period;
- Children and former foster youth aging out of Medicaid;
- Individuals losing the other benefits that were the basis of their Medicaid eligibility, such as Supplemental Security Income (SSI);
- People receiving coverage as a result of a pending administrative appeal; and
- People whose current address is unknown.

OHP intends for all members to retain coverage through their current CCO during the COVID-19 emergency.

Please note: Some OHP members receiving benefits on March 18, 2020 had previously been determined ineligible for benefits after March 31, 2020. The state is identifying and restoring their OHP benefits and CCO enrollment. A courtesy notice was mailed to them on April 20, 2020.

Hospital Presumptive Eligibility

During the COVID-19 emergency, applicants may apply for temporary OHP coverage through Hospital Presumptive Eligibility (HPE) by phone.

- They do not need to visit the hospital for a face-to-face interview to apply.
Hospitals will accept verbal signatures and mail denial or approval notices to the applicant. ODHS|OHA will honor application and decision forms completed according to the process outlined below.

**Authorized HPE application processors may conduct verbal determinations as follows:**

1. Review all information on the OHP 7260 application verbally with the applicant.
2. Ask the applicant whether they agree that the information reviewed is true and accurate as stated; the applicant’s answer will act as the verbal signature.
3. Put the applicant's name into the signature line with a note that signature was obtained verbally.
4. Review the approval or denial notice verbally with the applicant and tell them you will mail the notice to the address provided on the application.

Follow all other processes as normal, including entering the HPE end date and full application due date as the end of the month following the determination month; and directing applicants to complete full applications and how to do so. All forms and guidelines are found at bit.ly/ohp-hpe.

**Presumptive Eligibility determinations by OHP community partners**

During the COVID-19 emergency, OHP-certified community partners can perform Presumptive Eligibility determinations for temporary OHP coverage as follows:

- Individuals interested in completing Presumptive Eligibility applications must have an active assister ID.
- Upon completing training, they may enroll applicants using the same forms that hospitals use.
- The same process changes identified for Hospital Presumptive Eligibility sites apply to community partner sites.

OHA is making these changes to allow maximum flexibility in helping Oregonians to secure critical medical coverage, and to help reduce non-medical public use of hospitals during this time.

To qualify to make Presumptive Eligibility determinations, assisters should complete the two ODHS|OHA pre-recorded trainings and post-training quiz at bit.ly/ohp-hpe. Once this is done, they are considered qualified and may use the new process. Whenever possible, applicants should complete a full OHP application via the ONE Applicant Portal before using this new PE process.

**Temporary expansion of CAWEM-only (CWM) coverage**

During the COVID-19 emergency, the CAWEM emergency benefit will include all services for the diagnosis and treatment of COVID-19. COVID-19 vaccine administration is also covered when the diagnosis code Z23 (Encounter for immunization) is used for billing.

This coverage is not limited to emergency rooms and hospitals. OHA can reimburse providers for COVID-19-related services regardless of service location. Coverage includes non-emergency settings such as medical offices, urgent care and pharmacies.

Providers can bill OHA for COVID-19-related services provided on or after Feb. 1, 2020.

**References**

Federal legislation
The Family First Coronavirus Response Act (HR6201) authorizes these changes, effective 3/18/2020:
Expands access to Medicaid for those who are uninsured or at risk of losing Medicaid eligibility;
Adjusts eligibility and methodology for Medicaid;
Covers testing for COVID-19; and
Increases the Medicaid Federal Medical Assistance Percentage (FMAP).

The 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act (HR748):
- Authorizes the federal government to send stimulus checks to help families during the COVID-19 emergency;
- Increases unemployment payments; and
- Prohibits states from counting these payments when determining Medicaid eligibility.

Oregon Administrative Rules
410-200-0520 Temporary Eligibility Policy Changes Related to the COVID-19 Emergency Period

Previous guidance
This section incorporates and supersedes the following guidance:
- Temporary expansion of CAWEM-only (CWM) coverage (5/5/2020)
- Oregon Health Plan eligibility during COVID-19 emergency (3/31/2020)
- Changes to Hospital Presumptive Eligibility processes, effective immediately (3/24/2020)
- Community partners can now qualify to perform Presumptive Eligibility determinations (4/2/2020)

Rules superseded by OAR 410-120-0011 during the COVID-19 emergency
410-120-1210(4)(d)(C)(i) CAWEM coverage limitations
410-120-1210(4)(d)(D)(iv) Exclusion of preventive care from CAWEM benefit
Prior Authorization

Fee-for-service guidance is listed below. Please review this guide, notices received from OHA, and the OHP Prior Authorization page. If you still have questions or concerns, call the Provider Services Unit at 1-800-336-6016.

For CCO guidance, please contact the CCO.

Extension of approved prior authorization requests

If you received approval from OHA for physical health prior authorization requests but have been unable to provide the approved services due to the COVID-19 emergency, you can ask OHA to extend the end date of the approval. To do this:

- Fax a request to 503-378-5814 using the EDMS Coversheet. Mark the “Prior Authorization” box. In the “Justification” section, list your requested end date and the reason for the extension. In the “Documentation Identification Numbers” section, enter the 9-digit Prior Authorization Number of the approval you want to extend. OR
- Update the existing approval through the Provider Web Portal at https://www.or-medicaid.gov. In the “Attachments” section, upload a memo that lists your requested new end date and the reason for the extension.

The Provider Clinical Support Unit will review all extension requests on a case-by-case basis and approve extensions for medically necessary and appropriate services.

Urgent requests

The process has not changed. If waiting for approval of a prior authorization request is inhibiting a patient from being discharged or there is another immediate need for equipment or supplies, mark the request as “Urgent” (72 hours) or “Immediate” (24 hours). To do this:

- Mark the “Urgent” or “Immediate” box on the EDMS Cover Sheet. OR
- Select URG or IMM on your Provider Web Portal request. Call the PA Hotline at 1-800-336-6016 to make sure your request was received as an urgent or immediate request.

OHA responds to urgent or immediate requests daily. To follow up on any urgent or immediate PA request, please call the PA Hotline at 1-800-336-6016.

Extended State Fair Hearing requests and appeal timelines

When a prior authorization is denied, OHP members may have up to an additional 120 days to request a State Fair Hearing (or Contested Case Hearing). This gives OHP members up to 240 days to ask OHA for a hearing.
This temporary extension is effective March 1, 2020 and will end upon termination of the COVID-19 public health emergency.

For services denied by the CCO, CCO members must still ask their CCO for an appeal before asking OHA for a hearing.

During the COVID-19 emergency, CCOs will inform members about these extended timeframes by:

- Including information about the extension in member notices, including Notices of Benefit Denial and Notices of Appeal Resolution (Notices); and
- Sending correction letters to members who received Notices that contained only the pre-emergency hearing request timeframes.

OHA is also informing fee-for-service members and providers about the change.

**Extended deadline for submitting initial out-of-hospital birth requests**

While OHA still encourages providers to submit requests as early in the pregnancy as possible, OAR 410-130-0200 allows out-of-hospital birth providers an additional 7 weeks to submit prior authorization requests during the COVID-19 emergency.

- The original rule required providers to submit requests no later than 27 weeks, 6 days of gestation.
- Effective March 23, 2020, providers can submit requests no later than 34 weeks of gestation, to reduce potential exposure to COVID-19 for both the mother and newborn.

**References**

Oregon Administrative Rules
410-130-0200 Prior Authorization
410-130-0240 Medical Services

Rules superseded by OAR 410-120-0011 during the COVID-19 emergency

410-120-1860(4)(b)(A) 60-day deadline for FFS clients
410-141-3900(2)(a) 120-day deadline for CCO members
Billing OHA

Fee-for-service billing guidance is listed below. This information applies to health care providers enrolled with OHA as fee-for-service OHP providers. Please review this guide, notices received from OHA, and the OHP Billing Tips page. If you still have questions or concerns, call the Provider Services Unit at 1-800-336-6016.

For COVID-19 vaccine administration:
- Providers must be enrolled as both a fee-for-service OHP provider and as a COVID-19 vaccine provider through OHA’s Immunization Program.
- OHA has implemented a “No Wrong Door” policy to ensure access for CCO members who present at any OHP-enrolled COVID-19 provider location to receive a vaccine. This means providers not contracted with the member’s CCO may bill OHA for the vaccine administration.

For Medicare members, bill the member’s Medicare plan for the services Medicare covers, and list OHA or the member’s CCO as secondary. If only OHA covers the service, bill OHA.

For CCO billing guidance, please contact the CCO.

Dental claims

COVID-19 vaccine administration
OHP-enrolled COVID-19 vaccine providers may submit claims in the professional claim (CMS-1500 or 837P) format. See details below.

Dentists billing OHA for vaccine administration are subject to OAR 410-123-1262.

Interpreter services
Use CDT code D9990. The administrative add-on rate is $60 per date of service.

Teledentistry
Use Place of Service 02 regardless of whether the connection is by video with audio or regular telephone. Each service delivered via teledentistry will have two line items:
- D9995 (teledentistry)
- The code for the procedure delivered via teledentistry. List the fee on this line.

No modifier is required, as modifiers are not used on dental claims.
Physical and behavioral health claims

Catastrophe-related coding

To ensure appropriate payment, please use the following codes on all claims related to COVID-19:

- Professional claims: Enter modifier CR (Catastrophe/Disaster)
- Institutional claims: Enter Condition code DR (Disaster-Related)

This includes:

- The reason for a telehealth/telemedicine visit is for prevention of COVID-19 exposure (provider or patient). Prevention measures include physical distancing, limiting non-essential travel, and prioritizing personal protective equipment for essential health services. There is no requirement for either the patient or provider to have an actual or suspected COVID-19 diagnosis.
- Any assessment/treatment of COVID-19 (suspected or actual)

Please report these codes in addition to any other codes required by your program-specific rules and guidelines for the services billed. This will allow OHA to capture and report all COVID-19 spending and services to CMS.

Providers can use these codes to bill for qualified COVID-19-related services provided on or after Feb. 1, 2020. **Do not include** this coding on claims for telehealth/telemedicine services that would have been rendered absent the COVID-19 emergency. Examples may include:

- Weekly psychiatric service that has been regularly delivered by a behavioral specialist via telehealth/telemedicine;
- Routine telehealth/telemedicine visits conducted by RHCs for rural patients;
- Any telehealth/telemedicine services that would otherwise be routine, non-emergent telehealth/telemedicine visits.

COVID-19 vaccine administration

OHP-enrolled COVID-19 vaccine providers may bill for the vaccine administration, not the serum (also listed below for clarity). Use diagnosis code Z23 (Encounter for immunization) for billing.

<table>
<thead>
<tr>
<th>Code</th>
<th>Vaccine/Procedure Name</th>
<th>Include Code on Claims</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>91300</td>
<td>Pfizer-Biontech Covid-19 Vaccine</td>
<td>No. Federally supplied product</td>
<td>N/A</td>
</tr>
<tr>
<td>0001A</td>
<td>Pfizer-Biontech Covid-19 Vaccine Administration – First Dose</td>
<td>Yes. Add modifier CR</td>
<td>$16.94</td>
</tr>
<tr>
<td>91301</td>
<td>Moderna Covid-19 Vaccine</td>
<td>No. Federally supplied product.</td>
<td>N/A</td>
</tr>
<tr>
<td>0011A</td>
<td>Moderna Covid-19 Vaccine Administration – First Dose</td>
<td>Yes. Add modifier CR</td>
<td>$16.94</td>
</tr>
</tbody>
</table>

Interpreter services

Use HCPCS code T1013. The administrative add-on rate is $60 per date of service.

Monoclonal antibody administration

- Bill the usual and customary rate for the infusion and monitoring service with procedure code M0239 or M0243.
- Do not include billing code Q0239 or Q0243 for the drug since it was distributed to you at no cost.
- The appropriate NDC may be listed but is not required.
OHA’s reimbursement is at a per-service rate. Multiple units are not allowed.

**Professional billing (free-standing infusion centers, clinics and non-hospital settings)**
OHA’s maximum allowable rate for M0239 is $216.72.

**Institutional billing (hospital-based infusion centers)**
The outpatient hospital reimbursement for the administration is APC (OPPS).

**Telehealth/telemedicine services**
You may bill for these services retroactive to January 1, 2020.
- All telehealth/telemedicine in-person codes should be billed using Place of Service code 02.
- For services delivered by synchronous video and audio:
  - Use modifier 95 for physical health services, in addition to other appropriate modifiers
  - Use modifier GT for behavioral health services, as identified on the fee-for-service fee schedule.
- For services delivered by telephone (when synchronous audio and video is not available to the patient and/or provider), use Place of Service 02 with no other modifier. OHA will pay the non-facility rate for FFS claims using POS 02.

Facilities can bill for telehealth/telemedicine services using Q3014 if treating patient in a health care setting.

**For Medicare-Medicaid (dually eligible) members:**
If OHA and Medicare cover the same services via telehealth/telemedicine, bill Medicare first (list OHA or the CCO as secondary).

If OHA covers a service that Medicare does not (such as phone-based or online E/M services), bill OHA or the CCO directly. See OAR 410-120-1280 to learn more.

**Rebilling OHA**

**For telephone/online/quick check-in services:**
On May 1, 2020, OHA increased reimbursement for these codes for dates of service on or after March 1, 2020. To receive the increased reimbursement for claims submitted before May 1, please resubmit the claims.

**For in-person codes:**
You can bill back to March 13, 2020, when Guideline A5 was revised. If you originally submitted claims for in-person services using telephone/online codes, please resubmit the claims with the appropriate codes.

**For claims originally submitted with POS 11:**
OHA will pay the same rate for POS 11 or POS 02 (both non-facility RVU). During the COVID-19 emergency, providers should bill and code all telehealth/telemedicine services (A/V, audio, or online) with POS 02.

**Pharmacy claims**

**COVID-19 vaccine administration**
OHP-enrolled COVID-19 vaccine providers may bill through point of sale as follows. OHA will pay the fee (“Incentive Amount”) listed below.

**For two-dose vaccines:**
- The National Drug Code for both doses must be from the same manufacturer.
If the second dose is from a different manufacturer than the first dose, OHA will deny the claim for the second dose, requiring prior authorization.

Please call the Oregon Pharmacy Call Center at 888-202-2126 to request authorization.

<table>
<thead>
<tr>
<th>NCPDP Field</th>
<th>Two-Dose Vaccines: 1st Dose</th>
<th>Two-Dose Vaccines: 2nd Dose</th>
<th>Single-Dose Vaccines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Service Code 440-E5</td>
<td>MA</td>
<td>MA</td>
<td>MA</td>
</tr>
<tr>
<td>Service Clarification Code 452-DK</td>
<td>2</td>
<td>6</td>
<td>&lt;leave blank&gt;</td>
</tr>
<tr>
<td>Incentive Amount 483-E3</td>
<td>$16.94</td>
<td>$28.39</td>
<td>$28.39</td>
</tr>
<tr>
<td>Basis of Cost 423-DN</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Ingredient Cost Z 409-D9</td>
<td>$0.00 or $0.01</td>
<td>$0.00 or $0.01</td>
<td>$0.00 or $0.01</td>
</tr>
</tbody>
</table>

**Point of sale override instructions**

These override instructions apply only to these fee-for-service prescriptions covered by the Oregon Health Plan:
- Physical health drugs covered for chronic conditions for members not enrolled in a CCO, and
- Mental health drugs for all OHP enrolled members, including CCO members.

**Early refills for fee-for-service prescriptions**

For early refills of covered fee-for-service prescriptions, you will need to override the early refill (ER) edit by entering the following information:

<table>
<thead>
<tr>
<th>NCPDP Field</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Reason Code 439-E4</td>
<td>ER</td>
<td>Overutilization</td>
</tr>
<tr>
<td>Personal Service Intervention Code 440-E5</td>
<td>R0</td>
<td>Pharmacist consulted (other source)</td>
</tr>
<tr>
<td>Result of Service (Outcome Code) 441-E6</td>
<td>1B</td>
<td>Filled prescription as is</td>
</tr>
<tr>
<td>Submission Clarification Code (Intervention Code)</td>
<td>13</td>
<td><strong>Payer-Recognized Emergency/Disaster Assistance Request</strong>&lt;br&gt;<strong>This code justifies the early refill due to OHA’s recommendation to complete early refills for COVID-19 preparation</strong></td>
</tr>
</tbody>
</table>

**Call the Oregon Pharmacy Call Center to override denials due to delayed prescriber enrollment**

When a fee-for-service prescription denies because the prescriber has not yet enrolled with OHA, the pharmacy may call for a temporary override to process prescriptions written by non-enrolled prescribers.

Whenever possible, please also direct the prescriber to complete the OHP 3113 form at [bit.ly/3113form](https://bit.ly/3113form) and fax it to OHA at 503-378-3074 (Salem).

**Submit claims and documentation electronically**

To help reduce delays during this time, we ask that all providers submit claims and supporting documentation electronically when possible and review existing online resources prior to calling Provider Services.

**Electronic billing options**
If you submit more than 40 claims per week, electronic data interchange may be right for you. Your office management software may already be set up for it. To learn more, visit the Electronic Business Practices page.

Most enrolled Oregon Medicaid providers can use the Provider Web Portal at https://www.or-medicaid.gov to:
- Submit fee-for-service claims in real-time 24-hours a day, 7 days a week;
- Create copies of previously submitted claims and edit them for faster billing;
- Submit fee-for-service prior authorization requests and supporting documentation;
- Verify OHP eligibility, CCO enrollment, and Prioritized List coverage; and
- Request direct deposit and submit provider information updates.

All you need is a PIN, an internet connection and current browser. To learn more, visit the Provider Web Portal page.

New secure email options
You can now send the following documents via secure email to ODHS or OHA:
- **Newborn notifications** Send to OHP.Newborns@dhsoha.state.or.us. (This mailbox will only be available for the duration of the COVID-19 emergency.)
- **License/certification renewals**: Send to Provider.Enrollment@dhsoha.state.or.us.
- **Paper claims that require special handling, administrative review requests, consent forms, OHP 405T forms, OHP 1036 forms and provider appeals for claim reconsideration**: Send to OHA.FFSOHPClaims@dhsoha.state.or.us.
When sending documents via secure email to these addresses:

- Scan and attach documents to the email.
- Please send only one transaction per email.
- For special claims and claim documentation, please follow the instructions in OHA's fact sheet.

Online provider resources

The OHP for Providers website and Keys to Success provider guide offer a variety of resources to answer most questions about doing business as an Oregon Medicaid provider. You can also search for resources and frequently asked questions by topic or keyword on the Tools for Providers page.

Billing clients for non-covered services

Because they receive Medicaid benefits, OHP clients have special rights under federal and state law. It is against the law for you to require them to pay for any services covered by Medicaid, except when all of the following occurs:

1. OHA denies your PA request because it does not meet criteria
2. You submitted accurate, timely and complete documentation for the prior authorization request
3. The client signed a Medicaid-specific Agreement to Pay Form (OHP 3165) that shows they understand the services are not covered, and they agree to pay for them
4. You bill only for services provided after the date the client signed the OHP 3165 form

You may not bill the client for more than OHP’s usual reimbursement rate for the services. You may not collect a deposit or advance payment from an OHP client. Billing a client in any other circumstance constitutes fraud and may be prosecuted. OAR 410-120-1280(1)(b).

In addition, you may not bill the client:

- For any services OHP would not reimburse if the PA request had been approved.
- If OHA denies your PA request due to lack of complete, accurate, and timely documentation. OAR 410 120 1280(1)(b) requires that a “client may not be billed for services or treatments that have been denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained).

References

Oregon Administrative Rules

OAR 410-120-1280 Billing
OAR 410-123-1262 Dental Administration of Vaccines

Previous guidance

This section incorporates and supersedes billing guidance in the following documents:

- Add-on fee for interpreter services now open for fee-for-service payment (12/31/2020)
- Questions and answers from April 17 webinar (5/8/2020)
- Telehealth services provided by OT, PT, and Speech Therapists are covered by OHP (4/21/2020)
- OHA Telemedicine Webinar (4/17/2020)
- Expanded teledentistry coverage during the COVID-19 emergency (4/16/2020)
- Audio-only teledentistry services are also covered during the COVID-19 emergency (4/7/2020)
- OHA Telemedicine Webinar (4/6/2020)
- Telemedicine-telehealth billing guidance for Oregon Health Plan fee-for-service providers (4/6/2020)
- APCM establishing visits via telephone are permitted starting March 23 2020 (4/3/2020)
- How to bill for COVID-19 services to OHP members effective immediately (3/30/2020)
- Avoid processing delays by submitting claims and prior authorization requests electronically (3/20/2020)
- COVID-19 and early refills for fee-for-service prescriptions (3/11/2020)
- Expansion of fee-for-service telemedicine coverage (3/23/2020)
- Expanded telehealth coverage for behavioral health services (3/20/2020)
- Oregon Health Plan coverage of telemedicine services (3/13/2020)

### Rules superseded by OAR 410-120-0011 during the COVID-19 emergency

None.