

Oregon Medicaid COVID-19 Provider Guide



HEALTH SYSTEMS DIVISION

Coverage, billing and operational
guidance during the COVID-19
emergency

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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 Oregon Health Authority (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 and state guidelines for resuming elective and non-emergent services, [please refer to the Public Health Division's COVID-19 page for health care providers](#) and partners.

Testing, Screening and Treatment

This guidance applies to OHA’s fee-for-service coverage for Oregon Health Plan members and Citizen-Alien Waived Emergent Medical (CAWEM) members.

CAWEM recipients may obtain 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.

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

Covered services

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](#).

COVID-19 testing

Tests for current COVID-19 infection (CPT 87635, 87798 and HCPCS U0001, U0002, U0003 and U0004) are covered when medically appropriate and ordered by a qualified provider.

Code	Description
U0001	CDC 2019 novel coronavirus (2019-nCoV) real-time RT-PCR diagnostic panel
U0002	2019-nCoV coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC.
U0003	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.
U0004	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.
87635	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.
87798	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism

Antibody tests

COVID-19 antibody testing (also known as serology testing) to diagnose SARS-CoV-2 is covered only to evaluate a hospitalized person under age 21 for possible multisystem inflammatory syndrome in children (MIS-C).

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, effective April 10, 2020, paid at the indicated rates:

Code	Description	Rate
86328	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])	\$45.23
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	\$42.13

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

Other services

Please refer to the Health Evidence Review Commission’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.

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.

To reduce barriers to accessing quality and appropriate care for priority populations and advance Health Equity ([OHA's Health Equity definition](#)), the Oregon Health Authority (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](#) (Section 1557); 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 [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 Oregon Administrative Rules [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:

- Using OHA-approved HCIs, available on OHA's [HCI Registry](#);
- Using 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 telemedicine services preserve meaningful access to language services as described on the US 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 Telemedicine/Telehealth section of this guide](#).

Examples of situations that may **not** be appropriate for a 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.

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).

Previous guidance

This section incorporates guidance in the following documents:

- [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)

Telemedicine/Telehealth Coverage

During these challenging times, OHA understands that access to telehealth for physical, oral and behavioral health care is necessary and encourages all Oregon Health Plan 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 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 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 telephone/telemedicine services, contact [Provider Services](#) (800-336-6016).

If you have questions about CCO/DCO coverage of telephone/telehealth 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 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 telephone/telemedicine/telehealth coverage and reimbursement policies.
- CCO contracts require CCOs to ensure that 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 telemedicine/telehealth pay parity requirements for providers during the COVID-19 emergency OAR 410-141-3566 Telemedicine Payment Parity Requirements](#) (effective 3/26/2020-9/21/2020) requires CCOs to ensure payment parity for providers practicing telemedicine/telehealth.

This means CCOs must ensure that 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 telemedicine/telehealth 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 members of the Oregon Health Plan 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 telemedicine/telehealth and telephone platforms.

[Guideline Note A5](#) (Teleconsultations and non-face-to-face telehealth 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 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](#).
- 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 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 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 telemedicine services are appropriate.

OHA received federal authority to allow out-of-state providers to conduct 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](#).

Telemedicine/telehealth 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 (see guidance below).
- Members can receive telehealth or telephone 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).

Type of service	Telephone	Online/digital
E/M by a qualified physician: <ul style="list-style-type: none">■ MD, DO, naturopathic doctor	99441: 5-10 minutes of discussion 99442: 11-20 minutes of discussion 99443: 21-30 minutes of discussion	99421-99423
E/M by a qualified nonphysician: <ul style="list-style-type: none">■ Nurse practitioner, physician assistant, acupuncturist)	99441: 5-10 minutes of discussion 99442: 11-20 minutes of discussion 99443: 21-30 minutes of medical discussion	98970-98972
E/M by a qualified nonphysician: <ul style="list-style-type: none">■ Any type not able to bill E/M (e.g., RN, physical therapist, speech therapist, counselor, social worker)	98966: 5-10 minutes of discussion 98967: 11-20 minutes of discussion 98968: 21-30 minutes of discussion	G2061-G2063

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 be 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 telemedicine](#).

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, telemedicine services must comply with the following criteria, in addition to any program-specific requirements listed below.

- Oregon Administrative Rules (OAR) [410-120-1200](#) (excluded services and limitations),
- OAR [410-130-0610](#) (Telemedicine),
- [Guideline Note A5](#) (Teleconsultations and non-face-to-face telehealth services) from the [Prioritized List of Health Services](#).

Physical health services

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

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 telemedicine while providing evaluations and assessments for DME, when clinically appropriate.

Providers should follow the 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.

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 telemedicine.

Physical, occupational and speech therapy services

OHP will reimburse for the following therapy codes when provided through a telehealth 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 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 telemedicine for services that are not required to be provided face-to-face in an in-person setting.

To use 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 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 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 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 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 when in-person, face-to-face settings are not required.

The [Department of Human Services](#) and [Oregon Youth Authority](#) are responsible for determining when to permit 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 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 via 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 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 telemedicine.
- THWs employed by a Certified Substance Use Disorder (SUD) program can provide 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 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 telemedicine services

Oregon Administrative Rules (OAR) [410-146-0085](#) and [410-147-0120](#) now allow IHS/Tribal providers, FQHCs and RHCs to provide more 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 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](#).

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

- [HIPAA privacy and security standards](#)
- OHA's Privacy and Confidentiality Rules ([Chapter 943 Division 14](#))

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](#). For 42 CFR Part 2 (substance use disorder), see [guidance from the Substance Abuse and Mental Health Services Administration](#) (SAMHSA).

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 prior to the initiation of telehealth 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 (electronic signatures are acceptable).
- Clearly document how you obtained consent in the patient record.
- The initial consent is valid for one year.

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 telemedicine modalities preserve the quality of interpretation services by:

- Using [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 telemedicine services

Providers and CCOs must ensure 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 telemedicine platform must be obtained and documented in the medical record prior to providing services.
- Noting telemedicine delivery due to federal and state directives to practice physical distancing is advisable.
- For 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](#) (Teleconsultations and non-face-to-face telehealth services) from the Prioritized List of Health Services (revised April 3, 2020)

Oregon Administrative Rules

[410-120-1200](#) Excluded Services and Limitations

[410-123-1265](#) Teledentistry

[410-129-0075](#) Speech-Hearing

[410-130-0610](#) Telemedicine

[410-131-0040](#) 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 [Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020](#) (HR6074) expands telehealth services during the emergency declaration, effective 3/6/2020.

The [2020 Coronavirus Aid, Relief, and Economic Security \(CARES\) Act](#) (HR748) expands definition of telehealth service providers.

Previous guidance

This section incorporates and supersedes coverage, security, privacy, language access and documentation guidance in the following documents:

- [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)

Resources

Telehealth funding opportunity

The [COVID-19 Telehealth Program](#) will fully fund eligible providers' telecommunications services, information services, and devices necessary to provide critical connected care services until the program's funds have been expended or the COVID-19 pandemic has ended. The program is limited to the following types of nonprofit and public eligible health care providers:

- Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
- Community health centers or health centers providing health care to migrants;
- Local health departments or agencies;
- Community mental health centers;
- Not-for-profit hospitals;
- Rural health clinics;
- Skilled nursing facilities; or
- Consortia of health care providers consisting of one or more entities falling into the first seven categories.

Medical Transportation

This guidance is for partners who provide or approve medical transportation for Oregon Health Plan members, including:

- Fee-for-service transportation providers
- Coordinated care organizations
- 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 coordinated care organizations 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 coordinated care organizations

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 Oregon Health Plan 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 OAR 410-141-3920 and OAR 410-136-3020.

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, non-emergency ambulance (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 non-emergency ambulance (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 the OHA immediately at COVID.19@dhsosha.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@dhsosha.state.or.us.

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

CCOs, brokerages, and NEMT providers may allow drivers with expired Oregon driver licenses or vehicle registrations to serve Oregon Health Plan members if their license or registration expired during the period of

limited access to DMV offices due to the COVID-19 pandemic.

- This period of flexibility is for expirations from March 18, 2020, through October 1, 2020, the same end date as [the Oregon DMV's current law enforcement moratorium on citations](#).
- If the DMV's moratorium is extended past October 1, this period of flexibility is also automatically extended to the same date.

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 f. (2)(d)i. of the [CCO 2.0 contract](#) require CCOs to ensure that each NEMT driver has a valid driver license prior to hire. The contract also requires NEMT providers to document current vehicle registration. OAR [410-136-3040\(4\)\(a\)](#) requires NEMT brokerages to ensure that each subcontracted NEMT driver has a valid driver license prior to hire.

To ensure that these requirements are met during the moratorium, CCOs, brokerages, and NEMT providers must:

- Identify in their records each NEMT driver allowed to serve OHP members with an expired driver license or vehicle registration during the period of flexibility, and
- Require affected NEMT drivers to renew their expired driver licenses and vehicle registrations before the moratorium expires.

Please refer to the Oregon DMV's [COVID-19 web page](#) for information about the law enforcement moratorium (or "grace period").

References

Oregon Administrative Rules

OAR [410-136-3020](#) General Requirements for NEMT

OAR [410-136-3040](#) Vehicle Equipment and Subcontractor Standards

OAR [410-141-3920](#) Transportation: NEMT General Requirements

OAR [410-141-3925](#) Transportation: Vehicle Equipment and Driver Standards

Previous guidance

This section incorporates and supersedes the following guidance:

- [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)
- [COVID-19 Guidance for Non-Emergent Medical Transportation Providers](#) (3/27/2020)

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 Oregon Health Plan 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.

DHS|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 Oregon Health Plan (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 DHS|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 Citizen-Alien Waived Emergency Medical (CAWEM) emergency benefit will include all services for the diagnosis and treatment of COVID-19.

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 and urgent care

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 billing 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 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, Oregon Administrative Rule [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. 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 CCO billing guidance, [please contact the CCO](#).

Dental claims

For teledentistry services, 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 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 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 telemedicine;
- Routine telemedicine visits conducted by RHCs for rural patients;

- Any telemedicine services that would otherwise be routine, non-emergent telemedicine visits.

Telemedicine services

You may bill for these services retroactive to January 1, 2020.

- All telemedicine/telehealth 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 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 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 telemedicine services (A/V, audio, or online) with POS 02.

Pharmacy claims

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:

NCPDP field	Code	Description
Conflict Reason Code 439-E4	ER	Overutilization
Personal Service Intervention Code 440-E5	R0	Pharmacist consulted (other source)

NCPDP field	Code	Description
Result of Service (Outcome Code) 441-E6	1B	Filled prescription as is
Submission Clarification Code (Intervention Code) 420-DK	13	Payer-Recognized Emergency/Disaster Assistance Request <ul style="list-style-type: none"> This code justifies the early refill due to OHA's recommendation to complete early refills for COVID-19 preparation

Use Other Coverage Code (OCC) 1 to override denials for patients who have incorrect third-party liability (TPL) coverage on file

Please do this only **after**:

- Confirming with the member that they no longer have TPL (primary insurance), and
- Encouraging member to report TPL changes at www.ReportTPL.org.

If you confirm that the member still does have TPL, and the primary payer requires a prior authorization for payment, do not fill the prescription. The prescriber should initiate said authorization with that payer.

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 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, coordinated care organization 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 DHS 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, etc").

References

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

- [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.