

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 (CMS), 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 Oregon Health Plan (OHP) coverage during the COVID-19 emergency, email covid.19@dhsosha.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@dhsosha.state.or.us.

Other COVID-19 resources for providers

This guide pertains only to Medicaid coverage. For information about public health precautions, infection control guidance, vaccine administration, therapeutics distribution, state guidelines for resuming elective and non-emergent services and other clinical information, [please refer to OHA's COVID-19 page for health care providers](#) and partners.

Ensuring Health Equity During COVID-19

OHA is committed to ensuring that its programs and activities comply with civil rights laws such as [Oregon Revised Statute \(ORS\) 659A.403](#), the [Americans with Disabilities Act \(ADA\)](#), [Title VI of the Civil Rights Act of 1964](#) and [Section 1557 of the Affordable Care Act](#) and corresponding regulations [45 CFR Part 92](#), as established in OHA's [nondiscrimination policy and procedures for investigating reports of discrimination](#).

All OHA contractors and subcontractors, including OHP providers, coordinated care organizations (CCOs) and dental care organizations (DCOs), must comply with these laws. These requirements are not waived during the COVID-19 emergency.

National CLAS Standards

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.

To reduce barriers to accessing quality and appropriate care and advance Health Equity ([OHA's Health Equity definition](#)), OHA expects all OHP providers, CCOs and DCOs 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 [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 U.S. Department of Health and Human Services (HHS) [Office of Civil Rights Action Bulletin](#).

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.

OAR [410-141-3515\(12\)\(d\)](#) requires managed care entities (CCOs and DCOs) to ensure **all services** are provided according to National CLAS Standards.

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 meaningful access to language services

Providers, CCOs and DCOs must ensure all services, including telehealth/telemedicine services preserve meaningful access to language services as described on the [Office of Civil Rights website](#) and in [OHA's language and disability access page](#). This includes but is not limited to:

- American Sign Language (ASL) 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 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.

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

Reimbursement

Fee-for-service (FFS)

Starting January 1, 2021, and for the duration of the COVID-19 public health emergency, OHA will pay an administrative add-on fee for interpreter services at FFS health care visits (including telehealth visits). The fee, [as approved by CMS](#), 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

OHA requires CCOs and DCOs to reimburse certified and qualified 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 services in an equitable and inclusive manner

The [ADA](#) requires all health care providers to make reasonable modifications in policies, practices and procedures when necessary to serve or provide accommodations to people with disabilities.

- OAR [410-141-3515\(12\)\(e\)](#) requires CCOs and DCOs to comply with ADA requirements in providing access to covered services for all members and arrange for services to be provided by non-participating providers when necessary.
- OAR [410-141-3810\(4\)\(e\)\(A\)](#) requires CCOs and DCOs to ensure that providers and staff are educated about making disability accommodations.
- OAR [410-120-1380\(1\)\(c\)\(A\)\(3\)](#) requires all providers and subcontractors to ensure compliance with ADA requirements when providing health care services to OHP members.
- OAR [943-005-0060\(1\)\(c\)](#) requires all OHA contractors and subcontractors to establish non-discrimination and reasonable modifications policies. Section 5 of this rule also requires timely and meaningful notification to individuals about these policies.

Reasonable accommodations and COVID-19 safety protocols

Disabilities may prevent patients from being able to comply with safety procedures such as face covering protocols, COVID-19 testing prior to surgical procedures, or going to health care appointments without a support person. **People in such situations should not be denied access to care.** Instead, providers should provide reasonable accommodations as required by the ADA.

OHA's [Clinical Care, and Healthcare Infection Prevention and Control Recommendations for COVID-19](#) state:

- Providers should not deny care because the patient or the patient's caregiver is unable to wear a mask or face covering for medical reasons.
- Care should be provided with appropriate precautions for health care providers, other staff and members of the public.
- OHA's guidance is **not** intended to serve as a basis for denying emergency medical care to anyone, regardless of whether the patient is wearing a face covering or mask.

To maintain ADA compliance and meet OHA's requirements for CCOs, DCOs, OHP providers and all OHA contractors, please train staff and update your organization's policies and procedures to ensure reasonable accommodations for patients who indicate they cannot comply with COVID-19 policies due to a disability.

Training staff on ADA requirements

Please ensure that all staff (including front desk staff, schedulers and care coordinators) are trained on ADA requirements, including how to determine modifications in consultation with the patient or their representative when the need arises.

- Consider providing all staff the contact information of individuals within your health care system who are knowledgeable about the ADA to help minimize delays in service.
- Share OHA's clinical care guidance within your health care systems and provider networks.
- Share updated policies that outline the modifications staff may make in these situations.

Identify and develop reasonable accommodations

Identify reasonable modifications to policies, procedures, or protocols that ensure that people with

disabilities can access the care they need. Even if your organization has not yet experienced this issue, it is reasonable to anticipate such a situation.

For example, some common policy modifications to face covering requirements in a medical setting are:

- Increased personal protective equipment (PPE) for staff,
- First appointment of the day,
- Extended appointment for additional cleaning,
- A separate entrance,
- Curbside COVID-19 screening before entering a medical facility.

If the patient has a caregiver, support person or representative to help them navigate health care settings due to a disability, allow that person to be present at the appointment.

Responding to access to care concerns

If you know of OHP members with disabilities who have experienced barriers to accessing care due to COVID-19 restrictions, please:

- Refer CCO members to their CCO's care coordination team.
- Refer FFS members to OHP Care Coordination at 800-562-4620 or CareOregon Tribal Care Coordination at 844-847-9320 (for American Indian/Alaska Native FFS members).

The CCO and FFS care coordinators will work with the member's providers to develop appropriate modifications.

Member rights

Please note that members who are not provided reasonable modifications have the right to share their concerns with the following state and federal entities:

- [HHS Office of Civil Rights](#)
- [Oregon Bureau of Labor and Industries](#)
- [OHA Ombuds Program](#)

Additional resources

National and local resources about the ADA and reasonable modifications for people with disabilities:

- www.ADA.gov
- www.NWADACenter.org
- [Disability Rights Oregon](#)

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 at [45 CFR Part 92](#) (Section 1557)

[HHS Office of Civil Rights Action Bulletin](#)

Oregon Administrative Rules

[410-120-1380\(1\)\(c\)\(A\)\(3\)](#) Compliance with Federal and State Statutes

[410-141-3515\(12\)](#) Network Adequacy

[410-141-3810\(4\)\(e\)\(A\)](#) Disenrollment from MCEs

[410-141-3860\(12\)](#) Integration and Coordination of Care

[943-005-0060\(1\)\(c\)](#) Authority Contractors and Subcontractors

[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 cost of interpreter services is extended for fee-for-service payment](#) (5/18/2021)
- [Eliminating barriers to care for people with disabilities during the COVID-19 pandemic](#) (2/3/2021)
- [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 FFS coverage of COVID-19 vaccine, testing, screening and treatment for OHP and CWM members.

CWM members may obtain vaccines, tests and treatment at an emergency department, clinic, or urgent care that accepts open card (FFS) members. To learn more, refer to the [Medical Eligibility](#) section of this guide.

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

To learn about CCO or DCO coverage, please contact the [CCO](#) or [DCO](#).

Vaccine counseling

Counseling patients about COVID-19 vaccine, including advising them about the risks from getting and not getting vaccinated, is covered by OHP. Counseling-only visits and reimbursement for more than 20 minutes of counseling time is available only through the professional billing pathway.

Counseling with vaccine administration (same visit)

Reimbursement under the vaccine administration codes is for 20 minutes of counseling and the vaccine administration. Providers may bill separately for counseling that exceeds 20 minutes.

Counseling without vaccine administration (separate visit)

Counseling that does not occur during the vaccine administration visit is reimbursed under the Evaluation and Management (E/M) code appropriate for the time spent counseling.

Vaccine administration

OHP covers the administration of COVID-19 vaccine supplied to providers through allocations from the federal government. OHP will cover administration of additional products once they receive FDA approval or Emergency Use Authorization.

Reimbursement

See the [Billing section of this guide](#) for FFS program rates for the administration fee. No payment will be made for the vaccine serum.

Physical health and dental providers may bill OHA for FFS COVID-19 vaccine administration at these rates using the professional claim format. Hospitals may split bill vaccine administration as an outpatient service using the institutional 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 will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), including clinics participating in the Alternative Payment and Advanced Care Model (APCM) program, for COVID-19 vaccine administrations at the clinic's Medicaid Prospective Payment System (PPS) or encounter rate. To learn more about reimbursement for participating APCM clinics, [please read OHA's fact sheet](#).

OHA will reimburse Indian Health Care Providers (Indian Health Service, Tribal 638, and Urban Indian Health Programs) at the clinic's applicable encounter rate (a PPS rate or the Indian Health Service "OMB" rate).

Additional and booster doses

Instruct members to get second dose vaccines on the date specified by the manufacturer's product labeling for products that require a second dose.

[Refer to OHA's COVID-19 immunization protocol](#) for current guidance for COVID-19 immunization providers, including:

- The COVID-19 vaccine schedule
- Recommendations for use
- Contraindications, warnings and precautions,
- Recommendations for additional doses for immunocompromised individuals,
- Booster dose recommendations, and
- Other considerations.

Additional doses for moderate to severe immunodeficiency

OHP covers a third or fourth dose when recommended by a qualified health care provider. A patient's clinical team is best positioned to determine the degree of immune compromise and appropriate timing of vaccination.

- Moderately to severely immunocompromised persons should be offered a third dose.

Conditions causing moderate to severe immunodeficiency include:

- Active treatment for solid tumor and hematologic malignancies;
- Receipt of solid-organ transplant, including pretransplant vaccination, and taking immunosuppressive therapy;
- Receipt of CAR¹-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy);
- Moderate or severe primary immunodeficiency (e.g., DiGeorge, Wiskott-Aldrich syndromes);
- Advanced or untreated HIV infection;
- Active treatment with high-dose corticosteroids (i.e., ≥ 20 mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, TNF blockers, and other biologic agents that are immunosuppressive or immunomodulatory;
- Advanced or untreated HIV infection (people with HIV and CD4 cell counts $< 200/\text{mm}^3$, history of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV).

[Refer to OHA's COVID-19 immunization protocol](#) for additional information.

Children's COVID-19 and flu immunizations at OHP-enrolled pharmacies

To increase the number of places OHP-eligible children and families can go to access flu and COVID-19 immunizations, OHA will not require Vaccines for Children (VFC) program enrollment for:

¹ Chimeric antigen receptor. Added to a patient's T lymphocytes so that they recognize and attack cancer cells.

- Any OHP provider administering children’s COVID-19 immunizations; or
- Any OHP-enrolled pharmacies providing children’s flu immunizations, for the duration of the COVID-19 Public Health Emergency.

Pharmacies will need to enroll in the VFC program to provide any other children’s immunizations.

Additional payment for in-home COVID-19 vaccine administrations

OHA can reimburse providers an additional \$35.50 for administering COVID-19 vaccines to FFS OHP or CAWEM members in their home or dwelling, for dates of service on or after **June 8, 2021**. This fee:

- Is in addition to the base vaccine administration rates listed above,
- Applies only once per visit for members who are unable to leave to their home or otherwise difficult to reach as described in [the CMS fact sheet about the fee](#), and
- Does not apply to providers paid at an all-inclusive encounter rate for COVID-19 vaccine administration, including FQHCs, RHCs, and Indian Health Care Providers.

Code	Description	Place of Service Code	Effective Date	Rate
M0201	COVID-19 vaccine administration inside a patient's home; reported only once per home per date of service	04 (Homeless Shelter) 12 (Home) 13 (Assisted Living Facility) 14 (Group Home) 16 (Temporary Housing)	06/08/2021	\$35.50

Situations where the additional payment applies:

Providers may provide in-home vaccinations to patients who are unable to leave their home or otherwise difficult to reach. For example, the individual:

- Has a condition that makes them more susceptible to contracting a pandemic disease such as COVID-19.
- Is generally unable to leave the home, and if they do leave home it requires a considerable and taxing effort.
- Has a disability or faces clinical, socioeconomic, or geographical barriers to getting a COVID-19 vaccine in settings other than their home.
- Faces challenges that significantly reduce their ability to get vaccinated outside the home, such as challenges with transportation, communication, or caregiving.

Locations where the additional payment applies:

To be eligible for the additional payment, the COVID-19 vaccine may be administered in these locations:

- A private residence
- Temporary lodging (for example, a hotel or motel, campground, hostel, or homeless shelter)
- An apartment in an apartment complex or a unit in an assisted living facility or group home
- A patient's home is provider-based to a hospital during the COVID-19 public health emergency (i.e., [hospital at home](#))

You must document the patient’s clinical status or the barriers they face to getting the vaccine outside the home.

Expectations for CCO reimbursement

The CCO COVID-19 vaccine administration contract language specifies OHA reimbursement of CCO vaccine administration provider claims is “...limited to 100% of Medicare reimbursement, using the payment allowance published by CMS.”

- For vaccine administration claims for dates of service on or after March 15, 2021, CCOs must reimburse

at the \$40 per dose rate, and reprocess claims as needed to ensure payment at the \$40 per dose rate.

- For in-home vaccine administration claims for dates of service on and after June 8, 2021, CCOs must reimburse the \$35.50 per home fee and reprocess claims as needed to ensure payment at that rate.
- CCOs should notify OHA of issues or delays in reprocessing claims for enrolled providers that are anticipated to take more than thirty (30) calendar days.

COVID-19 vaccines administered to CCO members are eligible for FQHC/RHC supplemental wraparound payments, provided that these services would have been reimbursed at the clinic’s encounter rate had the patient been fee-for-service (“open card”).

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 has made 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 is enrolling 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](#).

Credentialing exemption for COVID-19 vaccine providers

OHA received approval from CMS to rely on enrollment and application materials of Medicare and other states’ Medicaid programs to enroll COVID-19 vaccination administration providers as OHP providers. CMS advised that OHA also has the authority to waive credentialing requirements for CCOs to enroll these providers for the purpose of COVID-19 vaccine administration. This means OHA and CCOs can bypass full credentialing for providers who are enrolled with any other state’s Medicaid program or with Medicare during the COVID-19 emergency.

OHA’s claim system requires a minimal amount of data about these providers to process FFS vaccine administration claims and report CCO encounter claims; however, CCOs will not be required to complete and document the full credentialing process in those cases.

To ease burden on both prospective vaccine administration providers and CCOs, OHA has filed a temporary change to OAR [410-141-3510](#). This rule change will allow CCOs to rely on the most recent weekly updates of OHA’s active file of COVID-19 vaccine administration providers in lieu of credentialing these providers.

CCOs will identify these providers in the weekly provider enrollment file by the word “COVID” in the license number field.

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 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.

Guidance for operating vaccination sites

Providers hosting vaccination sites should follow the recommendations in OHA’s guidance for vaccination sites. The guidance applies to all locations and staff operating COVID-19 vaccination sites in Oregon.

- OHA’s [Non-Discrimination Guidance](#) explains how to ensure that there are no barriers to receiving COVID-19 vaccines for communities of color, people who are deaf or hard of hearing, people who are deafblind, people with disabilities, and people who have limited English proficiency (LEP). Vaccinations must be provided in a manner that ensures access and must be provided to those who are eligible without racism or discrimination.
- OHA’s [Operational Guidance](#) explains the requirements all vaccination sites must follow.

Testing

OHP covers testing for COVID-19 as a diagnostic service. Tests used must have FDA EUA or approval as outlined in [OHA’s recommendations about COVID-19 testing](#). Refer to these recommendations to determine 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 CWM 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 [COVID-19 testing recommendations 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.

Code	Description	Effective
87426	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.	6/25/2020
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.	3/13/2020
87636	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique.	10/6/2020
87637	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.	10/6/2020
87798	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise	1/1/1998

Code	Description	Effective
	specified; amplified probe technique, each organism.	
87811	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]).	10/6/2020
U0001	CDC 2019 novel coronavirus (2019-nCoV) real-time RT-PCR diagnostic panel	2/4/2020
U0002	2019-nCoV coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC.	2/4/2020
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.	4/14/2020
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.	4/14/2020
U0005	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, CDC or non-CDC, making use of high throughput technologies, completed within 2 calendar days from date of specimen collection (list separately in addition to either HCPCS code U0003 or U0004) as described by CMS-2020-01-R2.	1/1/2021
87913	Infectious agent genotype analysis by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), mutation identification in targeted region(s)	2/21/2022
87428	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B	11/10/2020

Home test products

OHP covers self-administered home COVID-19 antigen testing kits through clinics and pharmacy point-of-sale (POS) for OHP and CWM members who have symptoms consistent with COVID-19 or who have had confirmed or suspected exposure to COVID-19. This coverage is for home tests as a diagnostic tool, not a general screening tool; and does not replace coverage for COVID-19 testing done in clinics and labs.

Qualifying products are tests FDA-authorized for over the counter (OTC) sale, including tests that require an internet connection or a smartphone for test interpretation.

CCOs do not need to allow non-pharmacy providers to supply or bill for COVID-19 home test kits provided to CCO members if pharmacies provide sufficient member access to home test kits.

OHP will cover up to eight units per month without a primary care provider's (PCP) order or prior authorization, at a rate of \$12 per test. OHP may cover more than eight units per month when ordered by the PCP as a necessary component of an individualized care plan.

Utilization management limits for COVID-19 home tests

For the purposes of determining the number of tests per month:

- One test is the collection and processing of one sample, regardless of package size or packaging directions.
- For example, a product that comes in a package with two tests and directs the user to use the second test 36 to 72 hours after the first is counted as two tests.

All other COVID-19 home test products require PCP order and prior authorization (PA).

Tests	Number per month	Limits allowed
Self-administered antigen tests authorized for OTC sale including tests that require an internet connection or a smartphone for test interpretation.	8	None. CCOs may not require PCP order/prescription PA.
Self-administered antigen tests authorized for OTC sale including tests that require an internet connection or a smartphone for test interpretation.	More than 8	CCOs may require PCP order/prescription and/or PA.
Home-sampled molecular diagnostic tests sent to a lab for analysis.	Any quantity	CCOs may require PCP order/prescription and/or PA.

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:

Code	Description	Effective	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])	4/10/2020	\$45.23
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative)	9/8/2020	\$42.13
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	4/10/2020	\$42.13

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.

Treatment

Monoclonal antibody administration

OHP covers monoclonal antibodies (mAb) and administration services, including subcutaneous injection or intravenous infusion and monitoring, in all health care settings where mAb may be appropriately and safely administered (including hospital, clinic, pharmacy or the patient's home).

- OHP will also reimburse providers for costs of purchased drugs.
- OHP will reimburse only injection/infusion and monitoring [for drugs obtained at no cost through the federal HHS allocation](#).

Coverage is limited to treatment or post-exposure prophylaxis of members who are at high risk for progression to severe COVID-19. Eligibility is based on risk factors that include but are not limited to the factors listed below.

- Age
- Obesity
- Diabetes
- Chronic lung disease
- Chronic kidney disease
- Cardiovascular disease
- Pregnancy
- Sickle cell disease
- Neurodevelopmental disease
- Medical-related technological dependence such as tracheostomy
- Other factors or medical conditions

Other factors can be associated with increased risk for progression to severe COVID-19, including race and ethnicity. For example, data show that patients of color or from Tribal communities are most harmed by health inequities, and the risks of hospitalization and death for these groups are greater than those of white patients. These patients may face higher risk than white patients due to longstanding societal injustices such as racism, discrimination and colonization, which have and continue to negatively impact health outcomes.

To bill for these services, check the member's OHP enrollment and bill the appropriate CCO or OHA.

OHA has also implemented a "no wrong door" policy for providers billing covered mAb services provided to eligible OHP members. This allows OHP-enrolled providers to bill OHA for mAb services if they cannot bill the member's CCO.

Monoclonal antibody administration by a pharmacist allowed effective September 1, 2021

The Oregon Board of Pharmacy approved mAb treatments by pharmacists beginning September 1, 2021. Pharmacists should:

- Review Oregon's drug therapy management protocol for [Oregon pharmacists prescribing and administering mAb treatments](#).
- Bill for pharmacist-rendered mAb services using the professional claim format. OHA's point of sale system will not accept claims for these services.

Oral ivermectin is not approved to treat or prevent COVID-19

OHA requires prior authorization (PA) for fee-for-service coverage of **oral ivermectin tablets** of any strength. Ivermectin for treatment or prevention of COVID-19 is not currently approved by the FDA or authorized by an EUA. At this time, use of oral ivermectin for COVID-19 should be limited to the clinical trial setting.

Oral ivermectin is a prescription-only product that is not covered or federally funded for use in COVID-19. Ivermectin can be associated with drug interactions and has teratogenic risk in pregnancy. Inappropriate use has also been linked to increases in ivermectin overdoses reported to state Poison Control Centers. Benefit for treatment or prevention of COVID-19 has not been established.

Federally supplied oral antiviral medications

Effective January 20, 2022, OHA covers the administration of oral antiviral medications distributed by pharmacies and billed through point of sale prescription claims. Coverage is for oral antiviral medications that are:

1. Authorized or approved by the FDA for COVID-19 treatment, and
2. Supplied directly or indirectly by the federal government at no charge to the dispensing pharmacy.

Pharmacies should bill OHA for all COVID-19 oral antiviral medications dispensed to OHP members, regardless of whether they are enrolled in a CCO.

Post-COVID (also known as “long COVID”) treatment

Effective October 22, 2021, OHA and CCOs must cover all medically appropriate treatments for post-COVID conditions, including:

- Condition and treatment pairs below the funding line of [the Prioritized List of Health Services](#) and
- Other treatments that OHP would not otherwise cover (e.g., excluded services).

OHA and CCOs will determine coverage based on case-by-case review for medical appropriateness.

No later than March 14, 2022, CCOs must begin to adjudicate claims in a manner consistent with this guidance. OHA will work with CCOs on a case-by-case basis to resolve any post-COVID claims that should have been covered for dates of service from October 22, 2021, through March 14, 2022.

OHA is currently researching all FFS post-COVID claims denied on or after October 22, 2021. OHA will also update the Medicaid Management Information System (MMIS) to suspend FFS post-COVID claims for prepayment review. When this update is completed, we will let you know.

For any post-COVID treatment, providers should [first verify whether OHP covers the service](#).

For services OHP already covers:

Continue to provide treatment and bill OHP (OHA or the CCO). This includes treatments that pair above the funding line, such as treatments for covered lung, heart, or kidney disorders. These services will not require additional authorization.

For services not covered by OHP:

For CCO members

Contact the CCO for details about authorization and billing. CCOs must establish a process for making medical necessity determinations, communicate it to providers and use this process to determine coverage.

- The process should not create unreasonable or arbitrary barriers to member access to these services.
- CCOs have latitude to choose the type of process. Acceptable processes include prior authorization, concurrent reviews, or pre-payment reviews.
- CCOs must also accept requests for reconsideration after claims denial. A process that only uses post-denial claim reconsiderations is not acceptable.

For members not enrolled in a CCO

Please provide treatment, but do not bill until OHA updates the MMIS to support prepayment review for all FFS post-COVID claims. OHA may request supporting documentation needed to make a medically necessary treatment determination.

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.

Coverage of home care through the Acute Hospital Care at Home waiver:

For hospitals that [receive federal approval to provide acute hospital care at home](#), hospital care provided at home will be considered an extension of the hospital.

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

Throughout the COVID-19 pandemic, hospitals have experienced situations in which a patient no longer requires inpatient level of care, but there is no capacity at an appropriate facility offering a lower level of care to which the patient can be discharged. As a result, the patient remains hospitalized while awaiting an opening in a facility.

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.

For OHP members not enrolled in a CCO:

OHA will pay hospitals for the portion of an inpatient stay when the patient no longer meets medical necessity criteria for inpatient level of care and is awaiting discharge to a lower level of care.

For CCO members:

OHA strongly encourages CCOs to adopt OHA's practice for CCO members experiencing barriers to discharge.

- Regardless of the payment arrangements CCOs choose to make with their contracted providers, CCOs should continue to participate in discharge planning with hospital staff for their members.
- Discharge planning and care coordination include outreach to and coordination with community and provider partners including, but not limited to local Oregon Department of Human Services (ODHS) offices and other social services entities, skilled nursing facility (SNF) providers, and home health care providers.

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.

Hospital transfers

OHA is making the following changes to help reduce the burden on Oregon’s hospitals and health systems as they respond to the current surge in COVID-19 hospitalizations. CCOs are encouraged to support these efforts with their providers.

Multiple transfers and reimbursement:

For in-state and out-of-state contiguous transfers (patient status 02 and 05), regional hospitals can use patient status 10 for back transfers to rural hospitals. Patient status 10 will bypass the current transfer policy (OAR [410-125-0165](#)) and allow the transferring regional hospital to receive the full DRG payment and outlier if applicable.

For transfers, please use patient status codes as appropriate.

- 02: Discharged/transferred to another short-term General Hospital for inpatient care
- 05: Discharged/transferred to a Designated Cancer Center or Children's Hospital
- 10: Discharge for back transfers to rural hospitals (defined by State Level, if necessary)

PA reviews paused for long-term acute care (LTAC) hospitals and inpatient rehabilitations:

For clients with fee-for-service (open card) medical benefits, OHA will automatically approve discharge to inpatient rehabilitation units and LTAC hospitals if the prior authorization request shows that:

- The billing and rendering providers are Medicaid-enrolled,
- The client has current OHP eligibility, and
- The requested services are paired above the funded line on the Prioritized List of Health Services.

Transportation to COVID-19 vaccination sites

OHP members can use non-emergent medical transportation (NEMT) to travel to the nearest local COVID-19 vaccination clinic, including alternative sites (e.g., fairgrounds, drive-through locations). [Refer to the NEMT section of this guide for more information.](#)

Additionally, OHP members receiving Medicaid-funded personal care services from a homemaker (HCW) or personal support worker (PSW) may be transported to the nearest local COVID-19 vaccination clinic, including alternative sites, by their HCW/PSW. These members should contact their local case management entity for more information and prior authorization.

Reimbursement for behavioral health personal care attendants

OHA will pay qualified and enrolled PCAs for mileage and time spent to transport individuals eligible for behavioral health (BH) PCA services to COVID-19 vaccination appointments. PCAs may be reimbursed for these costs for dates of service on and after Dec. 14, 2020, for the duration of the COVID-19 public health

emergency. This authorization covers the following:

- Mileage to and from the COVID-19 vaccination appointment in the PCA's own vehicle, using the most direct and reasonable route from the individual's home to the vaccination site.
- Time accompanying the individual at the vaccination appointment, if this service is not already included in the current service plan, or was not already claimed as part of the allotted time on their voucher for the pay period that the COVID-19 vaccination occurred.

If the individual wants to drive their own car, the PCA may only request reimbursement for time spent accompanying the individual.

PCAs may drive two individuals to a COVID-19 vaccination appointment only if both individuals agree to be transported together. All Oregon Public Health guidelines for COVID-19 must be followed. Payment will only cover the mileage and time associated with the appointment. A PCA will not be paid twice for the same trip.

Prior authorization through local case management or Comagine Health is **not** required.

How to request reimbursement

To request reimbursement, a PCA must:

- Complete the [PCA COVID-19 Vaccination Travel Tracking Sheet](#);
- Have the individual or their representative review and sign the tracking sheet; and
- Submit the tracking sheet with a copy of their driver's license and proof of current auto insurance.

PCAs can submit the tracking sheet in one of three ways:

- **Secure email:** PC.20@dhsosha.state.or.us;
- **Fax:** 503-945-5751 (Salem); or
- **Regular mail:** AMH Prov Pay, 500 Summer St NE E-86, Salem OR 97301.

An OHA representative may contact the PCA or the individual (consumer/employer) for additional information. Once OHA approves the request, OHA will issue payments in the next available payment cycle.

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.

[Medicare COVID-19 Vaccine Payment](#): On March 15, 2021, the Medicare rate for COVID-19 vaccine administration increased to \$40 per dose.

[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.

[CMS issued guidance October 22, 2021](#), clarifying that state Medicaid programs must cover medically necessary treatments and therapies for post-COVID conditions, sometimes called “long COVID.” Medically necessary treatment determinations must be made on a case-by-case basis and consider the particular needs of the individual and the judgment of health care professionals.

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.

Oregon Administrative Rules

[410-141-3510](#) Provider Contracting and Credentialing

Previous guidance

This section incorporates guidance in the following documents:

- [FFS reimbursement for self-administered COVID-19 test kits supplied by non-pharmacy providers, effective April 4, 2022](#) (7/26/2022)
- [OHP coverage of post-COVID \(sometimes called “long COVID”\) treatment](#) (2/17/2022)
- [OHP coverage of post-COVID \(sometimes called “long COVID”\) treatment](#) (2/11/2022)
- [FFS coverage of federally supplied oral antiviral COVID-19 treatments](#) (1/21/2022)
- [Hospital payments for members experiencing barriers to discharge](#) (1/21/2022)
- [Update to fee-for-service COVID-19 home testing coverage effective December 1, 2021](#) (11/19/2021)
- [OHP coverage of children’s COVID-19 and flu immunizations at OHP-enrolled pharmacies](#) (11/3/2021)
- [FFS coverage of COVID-19 home testing effective November 8, 2021](#) (10/29/2021)
- [FFS point of sale billing for COVID-19 and flu immunizations provided to OHP-eligible children](#) (10/22/2021)
- [Prior authorization required for fee-for-service coverage of oral ivermectin](#) (9/27/2021)
- [“No Wrong Door” for OHP providers billing for covered mAb services](#) (9/22/2021)
- [OHP coverage of pharmacist-administered monoclonal antibody treatment effective September 1, 2021](#) (9/3/2021)
- [OHP coverage for third dose of COVID-19 vaccine](#) (9/2/2021)
- [Changes to hospital transfer policy and PA requirements for LTAC hospitals and inpatient rehabilitation services, effective immediately](#) (8/27/2021)
- [OHP monoclonal antibody coverage for COVID-19 treatment](#) (8/26/2021)
- [Additional payment for in-home COVID-19 vaccine administration, effective June 8, 2021](#) (6/30/2021)
- [PCA reimbursement for transportation to COVID-19 vaccination sites](#) (6/3/2021)
- [Increase in reimbursement rate for COVID-19 vaccine administration](#) (3/17/2021)
- [Suspension of credentialing requirements for COVID-19 vaccination administration providers and requirements for encounter submissions for COVID-19 vaccinations](#) (3/12/2021)
- [FQHC/RHC reimbursement for COVID-19 vaccine administration](#) (3/12/2021)
- [OHP pharmacies can now bill COVID-19 vaccine administrations through point of sale](#) (2/5/2021)
- [OHP coverage of COVID-19 antibody testing](#) (10/23/2020)
- [OHP coverage of COVID-19 testing](#) (8/14/2020)
- [OHP 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
- 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 [410-120-1990\(5\)](#).

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 99202-99205, 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 and Management (E/M):** 99441-99443 for providers who can provide E/M services, such as physicians, physician assistants or nurse practitioners;
- **Assessment and 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:

- **E/M:** 99421-99423 for providers who can provide E/M services, such as physicians, physician assistants or nurse practitioners;
- **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 telehealth/telemedicine](#).

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 [410-120-1990](#) (Telehealth),
- [Guideline Note A5](#) (Telehealth, Teleconsultations and Online/Telephonic Services) from the [Prioritized List of Health Services](#),

For the duration of the COVID-19 [public health emergency](#), OHA permits providers who **only offer services via telehealth modalities** to enroll and provide medically appropriate services to OHP and CWM members.

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 durable medical equipment (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.

- A4663: 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 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 [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 (OAR [410-120-1990](#)) 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 PSCPs (must obtain written signature later).
- 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.

FQHCs, RHCs and HIS/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 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 HHS 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/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 self-addressed stamped envelope (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 the [ADA, Title VI of the Civil Rights Act, Section 1557 of the ACA](#) and corresponding federal law at [45 CFR Part 92](#) (Section 1557).

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.

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.

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 Language and Disability Access web page](#)

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

[410-120-1990](#) Telehealth

[410-123-1265](#) Teledentistry

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

[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/telemedicine services during the emergency declaration, effective 3/6/2020.

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 \(3/20/2020\)](#)
- [OHP coverage of telemedicine services \(3/13/2020\)](#)

Medical Transportation

This guidance is for partners who provide or approve medical transportation for OHP members, including:

- FFS transportation providers
- 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 the ALS1 Base Rate during the COVID-19 emergency.

FFS 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 FFA 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.

Reimbursement for NEMT to drive-through COVID-19 vaccination sites

OHA will reimburse FFS NEMT for trips associated with a drive-through COVID-19 vaccination, using HCPCS code T2007, at \$13.23 per 30-minute unit. The rate is effective for dates of service on and after January 1, 2021, for the duration of the COVID-19 public health emergency. For the trip to be reimbursable at this rate, the OHP member must:

- Arrive at the vaccination site in the provider's vehicle and
- Receive the COVID-19 vaccination without exiting the vehicle.

CCOs are encouraged to provide similar reimbursements for NEMT providers.

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 Emergency Management System (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, 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 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@dhs.oh.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@dhs.oh.state.or.us.

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

Effective January 1, 2022, the moratorium under House Bill 2137, waiving requirements that NEMT drivers may not be cited due to invalid driver's licenses and registrations has expired. CCOs, brokerages and NEMT providers previously following OHA guidance on expired Oregon DMV-issued driver licenses and vehicle registrations for NEMT drivers, under the authority of OAR 410-120-0011, must ensure drivers have current license and registration prior to providing an NEMT service.

The moratorium under HB 2137 ended on December 31, 2021, and may result in a citation for:

- Operating a vehicle without driving privileges, based on driver license or driver permit that is expired fewer than six months;
- Unlawful parking in a space reserved for persons with disabilities, based on a permit that is expired fewer than six months; or
- A tracking offense based on a vehicle registration or vehicle permit that is expired few than six months.

Documentation and renewal requirements

OAR [410-141-3925\(4\)\(a\)](#) and Exhibit B, Part 2, Section 5 g. (2)(d)i. of the [2022 CCO contract](#) require CCOs to ensure each NEMT driver has a valid license. The contract also requires NEMT providers to document current vehicle registration. OAR [410-136-3040\(4\)\(a\)](#) requires NEMT brokerages to also ensure each subcontracted NEMT driver has a valid license.

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

- Document confirmation that each NEMT driver maintains a current, valid driver license and vehicle registration and
- Require NEMT drivers to renew their expired driver licenses and vehicle registrations before providing transports on or after January 1, 2022.

NEMT brokerage flexibility to use private commercial transportation options

During the COVID-19 public health emergency, brokerages can allow Oregon Medicaid members to use private commercial transportation options, including taxicab companies and transportation network companies (TNCs) like Uber and Lyft. If their brokerage chooses to pursue this option, members can hail rides from these services and request reimbursement directly from the brokerage if the brokerage determines this option is the least costly, most appropriate mode of transportation available.

In accordance with the long-standing requirement of arranging for the least costly, most appropriate mode of transportation, the brokerage should:

- Screen members for primary options, including driving themselves, or having family members drive them.
- Explain to members that they can use a taxicab or TNC.
- Verify that the appointment is for a Medicaid-covered service.
- Approve the member to hail the TNC or taxicab, if that option is the least costly, most appropriate mode of transportation available.
- Explain to the member that after taking the ride, they should submit receipts and other necessary paperwork to the brokerage to request reimbursement as outlined in OARs [410-136-3240\(2\)](#) and [410-141-3960\(4\)](#).
- Reimburse members for these rides, following the same process used for client gas reimbursement.

References

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.

[Reimbursement for NEMT to drive-through COVID-19 vaccination sites](#): CMS approved this change on May 7, 2021.

CMS confirmed that OHA has the authority for client reimbursements for taxicab and TNC rides under Attachment 3.1-D (Assurance of Transportation) of Oregon’s Medicaid State Plan.

Oregon Administrative Rules

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

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

[410-136-3160](#) Ground and Air Ambulance Transports

[410-136-3300](#) Reports and Documentation

[410-136-3320](#) Audits

[410-141-3520](#) Record Keeping and Use of Health Information Technology

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

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

Previous guidance

This section incorporates and supersedes the following guidance:

- [Expired Oregon DMV-issued driver licenses and vehicle registrations for NEMT drivers](#) (1/24/2022)
- [Clarification regarding flexibility to use private commercial transportation options](#) (11/24/2021)
- [NEMT brokerage flexibility to use private commercial transportation options](#) (9/2/2021)
- [FFS NEMT reimbursement at drive-through COVID-19 vaccination sites](#) (7/30/2021)
- [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)
- [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 and CWM eligibility during the COVID-19 emergency

Starting March 18, 2020, if a member has Oregon Health Plan (BMH, BMD, BMM, CWX) or CWM coverage through a full eligibility determination, or obtained OHP or CWM eligibility since that date, they will continue to be covered at their approved benefit level throughout the COVID-19 emergency. This includes:

- Members who were scheduled for benefit closure due to redeterminations.
- CWM Plus (CWX) members who were scheduled to reduce to CWM-only (CWM) benefits. CWM Plus benefits will not be reduced during the COVID-19 emergency.

There are a few reasons why coverage would be closed during the pandemic. Please see the list of eligibility scenarios below for more information.

OHP or CWM eligibility will end only when:

- A member dies;
- A member becomes incarcerated. Benefits will be suspended while incarcerated;
- A member asks for their coverage to end;
- A member has moved out of state for a reason that is not related to the COVID-19 emergency, and does not intend to return to Oregon;
- OHA finds they approved medical benefits in error, or
- A court finds OHA approved medical benefits based on incorrect information that a member knowingly gave to OHA.

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 CWM-only (CWM) coverage

During the COVID-19 emergency, the CWM 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. It will also cover flu vaccinations.

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**. Providers can bill for flu vaccinations on or after **Nov. 4, 2021**.

Post-COVID (also known as “long COVID”) treatment is not included in the CWM benefit.

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:

- [CWM coverage of COVID-19 home tests and flu vaccinations during the COVID-19 public health emergency](#) (11/4/2021)
- [Temporary expansion of CWM-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\(4\)\(d\)\(C\)\(i\)](#) CWM coverage limitations

[410-120-1210\(4\)\(d\)\(D\)\(iv\)](#) Exclusion of preventive care from CWM 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, the rule allowed providers to submit requests no later than **34 weeks** of gestation.
- Effective Sept. 3, 2021, the rule allows providers to submit requests no later than **38 weeks** of gestation.

This extension is intended 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 or the member's CCO.

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 counseling

To bill for counseling provided separately from the vaccine administration visit, use the E/M code appropriate for the time spent counseling. Modifier 22 is not allowed with E/M codes.

COVID-19 vaccine administration

OHP-enrolled COVID-19 vaccine providers may bill for the vaccine administration, not the serum.

- Use diagnosis code Z23 (Encounter for immunization) for billing.
- OHA updated rates on 3/16/2021. OHP will work with you to adjust claims if you were paid the wrong rate on 3/15/2021.

To bill for counseling provided during the administration visit that exceeds 20 minutes, add modifier 22.

Ages 6 months through 4 years

Code	Description	Effective	Rate
0081A	Pfizer-BioNTech – Infant/Toddler First Dose	6/19/2022	\$40.00
0082A	Pfizer-BioNTech – Infant/Toddler Second Dose	6/19/2022	\$40.00
0083A	Pfizer-BioNTech – Infant/Toddler Third Dose	6/19/2022	\$40.00

Ages 6 months through 5 years

Code	Description	Effective	Rate
0111A	Moderna – Infant/Toddler First Dose	6/19/2022	\$40.00
0112A	Moderna – Infant/Toddler Second Dose	6/19/2022	\$40.00

Ages 5 to 11 years

Code	Description	Effective	Rate
0071A	Pfizer-BioNTech Pediatric – First Dose	11/2/2021	\$40.00
0072A	Pfizer-BioNTech Pediatric – Second Dose	11/2/2021	\$40.00
0073A	Pfizer-BioNTech Pediatric – Third Dose	1/3/2022	\$40.00
0074A	Pfizer-BioNTech Pediatric – Booster Dose	5/17/2022	\$40.00

Ages 12 years and older

Code	Description	Minimum age	Effective	Rates	
				Through 3/14/2021	On or after 3/15/2021
0001A	Pfizer-BioNTech – First Dose	16 years	12/13/2020	\$16.94	\$40.00
0001A	Pfizer-BioNTech – First Dose	12 years	5/13/2021	N/A	\$40.00
0051A	Pfizer-BioNTech – First Dose (preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation)	12 years	10/29/2021	N/A	\$40.00
0002A	Pfizer-BioNTech – Second Dose	16 years	12/13/2020	\$28.39	\$40.00
0002A	Pfizer-BioNTech – Second Dose	12 years	5/13/2021	N/A	\$40.00
0052A	Pfizer-BioNTech – Second Dose (preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation)	12 years	10/29/2021	N/A	\$40.00
0003A	Pfizer-BioNTech – Third Dose	12 years	8/12/2021	N/A	\$40.00
0053A	Pfizer-BioNTech – Third Dose (preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation)	12 years	10/29/2021	N/A	\$40.00
0004A	Pfizer-BioNTech – Booster Dose	18 years	9/22/2021	N/A	\$40.00
0004A	Pfizer-BioNTech – Booster Dose	16 years	12/09/2021	N/A	\$40.00
0004A	Pfizer-BioNTech – Booster Dose	12 years	1/5/2022	N/A	\$40.00
0054A	Pfizer-BioNTech – Booster Dose (preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation)	12 years	10/29/2021	N/A	\$40.00
0124A	Pfizer-BioNTech – Booster Dose (preservative free, 30 mcg/0.3 mL dosage, tri-sucrose bivalent formulation)	12 years	9/01/2022	N/A	\$40.00
0011A	Moderna – First Dose	18 years	12/18/2020	\$16.94	\$40.00
0012A	Moderna – Second Dose	18 years	12/18/2020	\$28.39	\$40.00
0013A	Moderna – Third Dose	18 years	8/12/2021	N/A	\$40.00
0064A	Moderna – Booster Dose	18 years	10/21/2021	N/A	\$40.00
0094A	Moderna – Booster Dose	18 years	3/29/2022	N/A	\$40.00
0134A	Moderna – Booster Dose (preservative free, 50 mcg/0.5 mL dosage, bivalent)	18 years	9/01/2022	N/A	\$40.00
0031A	Johnson & Johnson – Janssen – Single Dose	18 years	2/28/2021	\$28.39	\$40.00
0034A	Johnson & Johnson – Janssen – Booster Dose	18 years	10/21/2021	N/A	\$40.00
0041A	Novavax – First Dose	18 years	7/19/2022	N/A	\$40
0041A	Novavax – First Dose	12 years	8/22/2022	N/A	\$40
0042A	Novavax - Second Dose	18 years	7/19/2022	N/A	\$40
0042A	Novavax - Second Dose	12 years	8/22/2022	N/A	\$40

For in-home vaccine administration:

When billing OHA for FFS in-home COVID-19 vaccine administrations, bill for the \$35.50 fee as follows:

- **Procedure code:** Use M0201 (COVID-19 vaccine administration inside a patient's home; reported only once per home per date of service).
- **Place of Service code:** Use 04 (Homeless Shelter), 12 (Home), 13 (Assisted Living Facility), 14 (Group Home), or 16 (Temporary Housing).

For APCM clinics paid at the PPS encounter rate:

For COVID-19 vaccine administrations provided at a primary care medical visit, add the U1 modifier on FFS claims. This will allow OHA to pay for the vaccine administration at the PPS rate rather than zero pay. [Other services excluded from the APCM program](#) may also be paid at the PPS rate.

For hospital inpatient claims:

Split bill as an outpatient service as follows:

- Type of Bill: 131
- Statement Covers Period (From and To Dates): Use the discharge date of the inpatient claim.
- Condition Code: DR (Disaster-Related)
- Revenue Code: 771

For vaccine administration by non-OHP providers

Given the wide array of staffing models for vaccination sites, OHA recognizes the need for flexibility and relaxing administrative burdens. Therefore, OHA will allow vaccine administrations performed by non-enrolled providers to be billed under the supervising pharmacist or medical provider's Oregon Medicaid ID number.

This flexibility applies to sites with supervising pharmacists and other licensed professionals who are authorized to administer the COVID-19 vaccine **and** actively enrolled with OHP. For example:

- For traveling pharmacists who are not enrolled with OHP, the rendering provider should be the OHP-enrolled supervising pharmacist.
- For individuals who are not independently enrollable (e.g., EMTs, RNs, National Guard members), the rendering provider should be the OHP-enrolled supervising medical practitioner.

Additionally, any enrolled Licensed Health Care Professional (LHCP) can provide vaccinations when it is within their scope of practice. These include physicians, osteopaths, podiatrists, chiropractors, certified nurse practitioners, physician assistants, naturopathic physicians, dentists, nurses under the supervision of an LHCP, and pharmacists. Other types not listed may be able to vaccinate if they are supervised by existing licensed practitioners and perform services within the licensed practitioner's scope of practice.

Interpreter services

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

COVID-19 home test kits

To bill OHA for FDA-approved or cleared over the counter test kits:

- Use HCPCS K1034 for [professional claims](#) and revenue code 0300 for [institutional claims](#).
- Bill one unit of K1034 for each test. If a package contains two tests, bill two units.
- Please adjust previously submitted claims as described in the [Claim Adjustment Handbook](#).

Monoclonal antibody administration

For injection/infusion and monitoring services: Bill the usual and customary rate with the appropriate procedure code listed below.

- OHA’s reimbursement is at a per-service rate. Multiple units are not allowed.
- The appropriate NDC may be listed but is not required.

For drug products:

- Only bill for drugs purchased on the market. Include the NDC.
- Do not bill for drugs distributed to you at no cost through the federal HHS allocation.

Products listed with a rate of “N/A” are not currently available on the market and not eligible for billing.

[Visit the CDC website](#) for information on current availability and Emergency Use Authorizations.

- For professional billing (free-standing infusion centers, clinics and non-hospital settings), rates are listed below.
- For institutional billing (hospital-based infusion centers), the outpatient hospital reimbursement for the administration is APC (OPPS).

Drugs

Code	Description	Effective Date(s)	Rate
Q0239	Bamlanivimab, 700 mg	11/10/2020 – 04/16/2021	N/A
Q0243	Casirivimab and imdevimab, 2400 mg	11/21/2020	N/A
Q0244	Casirivimab and imdevimab, 1200 mg	06/03/2021	N/A
Q0245	Bamlanivimab and etesevimab, 2100 mg	02/09/2021	N/A
Q0247	Sotrovimab, 500 mg	05/26/2021	N/A
Q0249	Tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with COVID-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, 1 mg	06/24/2021	\$6.57

Subcutaneous injection

Code	Description	Effective Date(s)	Rate
M0240	Casirivimab and imdevimab, includes post-administration monitoring, subsequent repeat doses	07/30/2021	\$450.00
M0241	Casirivimab and imdevimab, includes post-administration monitoring in the home or residence, this includes a beneficiary's home that has been made provider-based to the hospital during the COVID-19 public health emergency, subsequent repeat doses	07/30/2021	\$750.00
M0243	Casirivimab and imdevimab, includes post-administration monitoring	11/21/2020 – 05/05/2021	\$309.60
M0243	Casirivimab and imdevimab, includes post-administration monitoring	05/06/2021	\$450.00
M0244	Casirivimab and imdevimab, includes post-administration monitoring in the home or residence; this includes a beneficiary’s home that has been made provider-based to the hospital during the COVID-19 public health emergency	05/06/2021	\$750.00

Intravenous infusion

Code	Description	Effective Date(s)	Rate
M0239	Bamlanivimab, includes post-administration monitoring	11/10/2020 – 04/16/2021	\$309.60
M0240	Casirivimab and imdevimab, includes post-administration monitoring, subsequent repeat doses	7/30/2021	\$450.00

Code	Description	Effective Date(s)	Rate
M0241	Casirivimab and imdevimab, includes post-administration monitoring in the home or residence, this includes a beneficiary's home that has been made provider-based to the hospital during the COVID-19 public health emergency, subsequent repeat doses	7/30/2021	\$750.00
M0243	Casirivimab and imdevimab, includes post-administration monitoring	11/21/2020 – 05/05/2021	\$309.60
M0243	Casirivimab and imdevimab, includes post-administration monitoring	05/06/2021	\$450.00
M0244	Casirivimab and imdevimab, includes post-administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the COVID-19 public health emergency	05/06/2021	\$750.00
M0245	Bamlanivimab and etesevimab, includes post-administration monitoring	02/09/2021 – 05/05/2021	\$309.60
M0245	Bamlanivimab and etesevimab, includes post-administration monitoring	05/06/2021	\$450.00
M0246	Bamlanivimab and etesevimab, includes post-administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the COVID-19 public health emergency	05/06/2021	\$750.00
M0247	Sotrovimab, includes post-administration monitoring	05/26/2021	\$450.00
M0248	Sotrovimab, includes post-administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the COVID-19 public health emergency	05/26/2021	\$750.00
M0249	Tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with COVID-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes post-administration monitoring, first dose	06/24/2021	\$450.00
M0250	Tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with COVID-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or ECMO only, includes post-administration monitoring, second dose	06/24/2021	\$450.00

For hospital inpatient claims:

Split bill as an outpatient service as follows:

- Type of Bill: 131
- Statement Covers Period (From and To Dates): Use the discharge date of the inpatient claim.
- Condition Code: DR (Disaster-Related)
- Revenue Code: 771 (admin)
- Revenue Code: 636 (drug)

Post-COVID (also known as “long COVID”) treatment

When billing for post-COVID treatments, list ICD-10 code U09.9 (Post COVID-19 condition, unspecified) as a secondary diagnosis when the primary condition being treated arose from an earlier COVID-19 infection. OHA will not accept U09.9 as a primary diagnosis.

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. OHA updated rates on 3/16/2021. OHP will work with you to adjust claims if you were paid the wrong rate on 3/15/2021.

NCPDP Field	Multi-Dose Vaccines					Single-Dose Vaccines	
	Rates through 3/14/2021		Rates on and after 3/15/2021			Rates through 3/14/2021	Rates on and after 3/15/2021
	1 st Dose	2 nd Dose	1 st Dose	2 nd Dose	3 rd Dose		
Professional Service Code 440-E5	MA	MA	MA	MA	MA	MA	MA
Service Clarification Code 452-DK	2	6	2	6	7	<leave blank>	<leave blank>

NCPDP Field	Multi-Dose Vaccines					Single-Dose Vaccines	
	Rates through 3/14/2021		Rates on and after 3/15/2021			Rates through 3/14/2021	Rates on and after 3/15/2021
	1 st Dose	2 nd Dose	1 st Dose	2 nd Dose	3 rd Dose		
Incentive Amount 483-E3	\$16.94	\$28.39	\$40.00	\$40.00	\$40.00	\$28.39	\$40.00
Basis of Cost 423-DN	15	15	15	15	15	15	15
Ingredient Cost 409-D9	\$0.00 or \$0.01	\$0.00 or \$0.01	\$0.00 or \$0.01	\$0.00 or \$0.01	\$0.00 or \$0.01	\$0.00 or \$0.01	\$0.00 or \$0.01

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:

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

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).

COVID-19 OTC home test kits

Use the pharmacy NPI or an enrolled pharmacist's NPI as the prescribing provider in NCPDP data field (111-AM).

Federally supplied oral antiviral medications

Bill OHA (not the member's CCO) for federally supplied oral antiviral COVID-19 treatments dispensed to OHP and CWM members. OHA will pay the dispensing fee for these medications on a FFS basis for all members, regardless of whether they are enrolled in a CCO. Bill with the appropriate NDC.

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

[410-120-1280](#) Billing

[410-123-1262](#) Dental Administration of Vaccines

Previous guidance

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

- [FFS reimbursement for self-administered COVID-19 test kits supplied by non-pharmacy providers, effective April 4, 2022](#) (7/26/2022)
- [Fee-for-service coverage of COVID-19 home testing policy update](#) (11/19/2021)
- [Suspension of credentialing requirements for COVID-19 vaccination administration providers & requirements for encounter submissions for COVID-19 vaccinations](#) (3/12/2021)
- [FQHC/RHC Reimbursement for COVID-19 Vaccine Administration](#) (3/12/2021)
- [OHP pharmacies can now bill COVID-19 vaccine administrations through point of sale](#) (2/5/2021)
- [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)
- [OHP coverage of telemedicine services](#) (3/13/2020)

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

None.