6-14

Secretary of State
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PERMANENT ADMINISTRATIVE RULES

OMAR 26-2006

I certify that the attached copies* are true, full and correct copies of the PERMANENT Rule(s) adopted on 6/3/2006 by the
Date prior to or same as filing date

Department of Human Services, Office of Medical Assistance Programs 410
Agency and Division Administrative Rules Chapter Number

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to become effective 7/1/2006. Rulemaking Notice was published in the 5/1/2005 *Oregon Bulletin.***
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RULEMAKING ACTION

Rule Filing Caption: July 2006- Current Procedural Terminology code updates for Medical-Surgical Services

AMEND: 410-130-0180, 410-130-0190, 410-130-0200, 410-130-0220, 410-130-0225, 410-130-0240, 410-130-0255, 410-130-0580, 410-130-0585, 410-130-0587, 410-130-0595, 410-130-0670, 410-130-0680 and 410-130-0700

Stat. Auth.: ORS 409.010, Department of Human Services function, recipient of federal funds, or Chapter(s), 409.110; Authority of Director; and ORS 409.050, Rules.
Other Auth: None
Stats. Implemented: ORS 414.065

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RULE SUMMARY

The Medical-Surgical Services program rules govern payment for the Office of Medical Assistance Programs' (OMAP) payments for services provided to certain clients. OMAP amended rules as follows: 410-130-0180, to require providers to add the National Drug Code (NDC) of drugs administered in their offices to the 837P billing format and remove reference to covered codes; 410-130-0190, to remove references to covered codes; 410-130-0200, to remove codes deleted from HCPCS; 410-130-0220, to remove deleted codes and add new CPT codes; 410-130-0255, to add vaccine codes supplied by the Vaccines for Children's Program; 410-130-0580, to remove billing instructions and to clarify that the person obtaining consent cannot sign the Sterilization Consent form retroactively; 410-130-0595, to add requirement to assist in making referrals for dental services; to clarify all mandatory topics must be reviewed for Full Case Management, and to add Mercury Consumption of fish to the training topics in Table 130-0595-2. Rules listed above are amended for necessary housekeeping corrections.

Lynn Read 6/7/06
Lynn Read, Authorized Signer Date

410-130-0180
Drugs
(1) The Office of Medical Assistance Programs' (OMAP) Medical-Surgical Services Program reimburses practitioners for drugs only when administered by the practitioner in the office, clinic or home settings. OMAP does not reimburse practitioners for drugs that are self-administered by the client, EXCEPT contraceptives such as birth control pills, spermicides and patches:
(a) Use an appropriate CPT therapeutic injection code for administration of injections;
(b) Use an appropriate HCPCS code for the specific drug. Do not bill for drugs under code 99070;
(c) When billing unclassified drugs and other drug codes listed below, bill at acquisition cost (purchase price plus postage) and use the following codes:
(A) J1815-J1816;
(B) J3490;
(C) J7699;
(D) J7799;
(E) J8499;
(F) J8999
(G) J9999;
(H) Include the name of the drug, NDC number, and dosage. (d) Do not bill for local anesthetics. Reimbursement is included in the payment for the tray and/or procedure.
(2) The Office of Medical Assistance (OMAP) requires both the NDC number and HCPCS codes for claim submission on the electronic 837P form.
(3) For Not Covered/Bundled services or Prior Authorization Requirements refer to OAR 410-130-0200 Table 130-0200-1 and OAR 410-130-0220 Table 130-0220-1.
(4) Not covered services include:
(a) Laetrile;
(b) Home pregnancy kits and products designed to promote fertility;
(c) DMSO, except for instillation into the urinary bladder for symptomatic relief of interstitial cystitis;
(d) Infertility drugs;
(e) Sodium hyaluronate and Synvisc (J7317 and J7320).
(5) Follow criteria outlined in the following:
(a) Billing Requirements -- OAR 410-121-0150;
(b) Brand Name Pharmaceuticals -- OAR 410-121-0155;
(c) Prior Authorization Procedures -- OAR 410-121-0060;
(d) Drugs and Products Requiring Prior Authorization -- OAR 410-121-0040;
(e) Drug Use Review -- OAR 410-121-0100;
(f) Participation in Medicaid's Prudent Pharmaceutical Purchasing Program -- OAR 410-121-0157.
(6) Clozapine Therapy:
(a) Clozapine is covered only for the treatment of clients who have failed therapy with at least two anti-psychotic medications;
(b) Clozapine Supervision is the management and record keeping of Clozapine dispensing as required by the manufacturer of Clozapine:
(A) Providers billing for Clozapine supervision must document all of the following:
(i) Exact date and results of White Blood Counts (WBC), upon initiation of therapy and at recommended intervals per the drug labeling;
(ii) Notations of current dosage and change in dosage;
(iii) Evidence of an evaluation at intervals recommended per the drug labeling requirements approved by the FDA;
(iv) Dates provider sent required information to manufacturer.
(B) Only one provider (either a physician or pharmacist) may bill per week per client;
(C) Limited to five units per 30 days per client;
(D) Use code 90862 with modifier TC to bill for Clozapine supervision.
Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

410-130-0190
Tobacco Cessation
(1) Tobacco treatment interventions may include one or more of these services: basic, intensive, and telephone calls.
(2) Basic tobacco cessation treatment includes the following services:
(a) Ask -- systematically identify all tobacco users -- usually done at each visit;
(b) Advise -- strongly urge all tobacco users to quit;
(c) Assess – the tobacco user's willingness to attempt to quit using tobacco within 30 days;
(d) Assist -- with brief behavioral counseling, treatment materials and the recommendation/prescription of tobacco cessation therapy products (e.g., nicotine patches, oral medications intended for tobacco cessation treatment and gum);
(e) Arrange -- follow-up support and/or referral to more intensive treatments, if needed.
(3) When providing basic treatment, include a brief discussion to address client concerns and provide the support, encouragement, and counseling needed to assist with tobacco cessation efforts. These brief interventions generally are provided during a visit for other conditions, and additional billing is not appropriate.
(4) Intensive tobacco cessation treatment is on the Health Services Commission's Prioritized List of Health Services and is covered if a documented quit date has been established. This treatment is limited to ten sessions every three months. Treatment should be reserved for those clients who are not able to quit using tobacco with the basic intervention measures.
(5) Intensive tobacco cessation treatment includes the following services:
(a) Multiple treatment encounters (up to ten in a 3 month period);
(b) Behavioral and tobacco cessation therapy products (e.g., nicotine patches, oral medications intended for tobacco cessation treatment and gum);
(c) Individual or group counseling.
(6) Telephone calls: A telephone call intended as a replacement for face-to-face contact with clients who are in intensive treatment may be reimbursed as it is considered a reasonable adjunct to, or replacement for, scheduled counseling sessions:
(a) The call should last five to ten minutes and provides support and follow-up counseling;
(b) The call should be conducted by the provider or other trained staff under the direction or supervision of the provider;
(c) Enter proper documentation of the service in the client's chart.
(7) Diagnosis Code ICD-9-CM 305.1 (Tobacco Use Disorder):
(a) Use as the principal diagnosis code when the client is enrolled in a tobacco cessation program or if the primary purpose of the visit is for tobacco cessation services;
(b) Use as a secondary diagnosis code when the primary purpose of this visit is not for tobacco cessation or when the tobacco use is confirmed during the visit.
(8) Billing Information: Managed care plans may have tobacco cessation services and programs. This rule shall not limit or prescribe services a Prepaid Health Plan provides to clients receiving the Basic Health Care Package.
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

410-130-0200
Prior Authorization/Prior Notification
(1) Prior Authorization:
(a) Prior authorization (PA) for services provided to clients enrolled in a prepaid health plan (PHP) must be obtained from the appropriate PHP. Contact the PHP for their PA requirements and billing instructions.
(b) PA is not required for services covered by Medicare to clients who have both Medicare and Medical Assistance Program coverage. However, PA is required for most transplants, even if they are covered by Medicare.
(c) PA is not required for kidney and cornea transplants unless they are performed out-of-state.
(d) PA must be obtained from the Office of Medical Assistance Program's (OMAP) Transplant Coordinator for transplants and non-emergent, non-urgent out-of-state services. Refer to the OMAP Transplant Services rules (Chapter 410, Division 124) for further information on transplants and refer to the OMAP General Rules (Chapter 410, Division 120) for further information concerning out-of-state services.
(e) PA must be obtained from the Department of Human Services (DHS) Medically Fragile Children's Unit (MFCU) for services provided to MFCU clients.
(f) PA for services provided to clients enrolled in the fee-for-service (FFS) High Risk Medical Case Managed program must be obtained from the Case Management Contractor shown on the client's Medical Care ID. See the Medical-Surgical Services Supplemental Information guide for details.
(g) PA is required for all procedure codes listed in Table 130-0200-1 in this rule. PA for these procedures must be obtained from the Oregon Medical Professional Review Organization (OMPRO) regardless of the setting they are performed in. A second opinion may be requested by OMAP or OMPRO before PA is given for a surgery;
(h) PA is not required for hospital admissions unless the procedure requires PA;
(i) PA is not required for emergent or urgent procedures or services;
(j) PA must be obtained by the treating and performing practitioners;
(k) Refer to Table 130-0200-1 for all services/procedures requiring prior authorization.
(2) Prior Notification:
(a) Prior notification is required before performing the following radiology tests:
(A) MRIs;
(B) MRAs;
(C) CTs;
(D) CTAs; and
(E) SPECT scans.
(b) Prior notification is not required when these tests are performed during an emergency department visit or an inpatient stay;
(c) Providers ordering these tests must submit a prior notification form to OMAP prior to the performance of the tests;
(d) Refer to the Medical-Surgical Supplemental Information guide for instructions and forms;
(e) Refer to Table 130-0200-2 for radiology codes requiring prior notification.
Table 130-0200-1
Table 130-0200-2
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

Table 130-0200-1 Prior Authorization

For numbers followed by (*#) see bottom of table for additional information.

00580	22630	51841
00796	22632	51845
00938	22800	54360
11960	22802	54400
11970	22804	54401
15822	22808	54405
15823	22810	54408
17106-17108 (*1)	22812	54410
20910	22841-22848	54411
21050	22851	54416
21120	23472	54417
21121	26560-26562	56805
21137-21139	27447	57267
21141-21143	28340	57283
21145-21147	28341	57284
21150	28344	57288
21151	28345	57291
21154	30400	57292
21155	30410	57335
21159	30420	58150
21160	30430	58152
21172	30435	58180
21175	30450	58260
21179-21184	30460	58262-58263
21188	30462	58267
21193-21196	32851-32856 (*2)	58270
21198	33933 (*2)	58275
21199	33935 (*2)	58280
21206	33944-33945 (*2)	58285
21208	33979	58290-58294
21209	38204-38215 (*2)	58400
21256	38230 (*2)	58410
21260	38240 (*2)	58550
21261	38241 (*2)	58552-58554
21263	40840	58660
21267	40842-40845	58661
21268	43631-43634	58672
21270	44135 (*2)	58673
21275	44715-44721 (*2)	58720
21280	47135 (*2)	58940
22554	47136 (*2)	62351
22556	47140-47147 (*2)	63001
22558	48160 (*2)	63003
22585	48551-48552 (*2)	63005
22590	48554 (*2)	63011-63012
22595	48556 (*2)	63015-63017
22600	49000 (*3)	63020
22610	49320	63030
22612	49329	63035
22614	51840	63040

63042-63048
63050-63051
63055-63057
63064
63066
63075-63078
63081
63082
63085-63088
63090
63091
63101-63103
63170
63172-63173
63180
63182
63185
63190
63191
63194-63200
63250-63252
63265-63268
63270-63273
63275-63278
63280-63283
63285-63287
63290
63295
63300-63308
65125
65130
65135
65140
65150
65155
67311 (*4)
67312 (*4)
67314 (*4)
67316 (*4)
67318 (*4)
67320 (*4)
67331 (*4)
67332 (*4)
67334 (*4)
67335 (*4)
67340 (*4)
67550
67560
67900-67904
67906
67908
67909
67911
67912
67914-67917
78459
78491
78492
78608
78609
78811-78816
92507
S2053 (*2)
S2065 (*2)
S2142 (*2)
S2150 (*2)
S2350
S2351

(*1) Authorized for facial lesions only, if meets other PA requirements
(*2) Contact the Medical Director's Office
(*3) PA required if an elective procedure
(*4) PA not required for clients under age 21

Table 130-0200-2 Prior Notification

70450
70460
70470
70480-70482
70486-70488
70490-70492
70496
70498
70540
70542-70549
70551-70553
70557-70559
71250
71260
71270
71275
71550-71552
71555
72125-72133
72141-72142
72146-72149
72156-72159
72192-72198
73200-73202
73206
73218-73223
73225
73700-73702
73706
73718-73723
73725
74150
74160
74170
74175
74181-74183
74185
75552-75556
76070-76071
76355-76370
76400
78205-78206
78320
78459
78464-78465
78469
78491-78492
78494
78607-78609
78647
78710
78803

410-130-0220
Not Covered/Bundled Services
(1) Refer to the Oregon Health Plan Administrative Rules (Chapter 410, Division141) and General Rules (Chapter 410, Division 120) for coverage of services. Refer to Table 130-0220-1 for additional information regarding not covered services or for services that are considered by OMAP to be bundled.
(2) The following are examples of not covered services:
(a) Psychotherapy services (covered only through local Mental Health Clinics and Mental Health Organizations);
(b) Routine postoperative visits (included in the payment for the surgery) during 90 days following major surgery (global period) or 10 days following minor surgery;
(c) Services provided at the client's request in a location other than the practitioner's office that are normally provided in the office;
(d) Telephone calls for purposes other than tobacco cessation and maternity case management.
(3) This is not an inclusive list. Specific information is included in the Office of Medical Assistance Programs (OMAP) General Rules, Medical Assistance Benefits: Excluded Services and Limitations (OAR 410-120-1200).
Table 130-0220-1
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

Table 130-0220-1 Not Covered/Bundled Services
Refer to the HSC List for additional not covered services.
BND = bundled services that are included in the base service
For numbers followed by (*#), see additional information below.

00802	92354	G0219	L6975
19316	92355	G0235	L7010
32850 BND	92508	G0252	L7015
33930 BND	92559	G0370	L7020
33940 BND	92592	J3520	L7025
44132 BND	92593	J3570	L7030
44133	92595 (*2)	K0000-K9999	L7035
44136	96150-96155	L1844	L7040
47133BND	97010 BND	L2750	L7045
48550 BND	97016	L2780	L7170
58740 BND	97018	L3251	L7180
74740	97024	L5610	L7185-L7186
74742	97026	L5613-L5614	L7190-L7191
77422	97028	L5722	L7260-L7261
77423	97033	L5724	L7266
78459	97034	L5726	L7272
78491	90735	L5728	L7274
78492	97039	L5780-L5822	L7360
78990 (*1)	97139	L5824	L7362
79900 (*1)	97537	L5828	L7364
80414-80415	97802-97804	L5830	L7366-L7368
82757	99000-99002	L5848	L7500
84030	BND	L5980	L7520
84830	99024	L5989	L7900
86910-86911	99026	L6025	L8001-L8002
88000-88099	99027	L6310	L8010
89235	99056	L6360	L8035
89240	99070 (*1)	L6638	L8039
89250-89261	99071 BND	L6646	L8500-L8501
89264	99075	L6648	L8505
89268	99100 BND	L6825	L8507
89272	99116 BND	L6875	L8510-L8514
89280-89281	99135 BND	L6881-L6882	L8600
89290-89291	99140 BND	L6920	L8603
89300	99360 (*3)	L6925	L8606
89310	A4570 (*4)	L6930	L8610
89320-89321	A4580 (*4)	L6935	L8612-L8614
89325	A4590 (*4)	L6940	L8619
89329-89330	A4641-A4642	L6945	L8630-L8631
89335	BND	L6950	L8641-L8642
89342-89344	B4034-B4036	L6955	L8658-L8659
89346	B4100-B9999	L6960	L8670
89352-89354	E Codes (*5)	L6965	L8699
89356	G0166	L6970	L9900

M0075	P2031	P9016-P9023	Q0092 BND
M0076	P2033	P9031-P9048	Q0114-Q0115
M0100	P2038	P9050-P9060	
M0300-M0301	P7001	Q0035	
P2028-P2029	P9010-P9012	Q0091 BND	

(*1) Use HCPCS
(*2) Not covered for ages 21 and older
(*3) Covered only for standby at cesarean/high-risk delivery of newborn
(*4) Use Q4001-Q4051
(*5) Refer to DME Table 130-0700-1

410-130-0225
Teaching Physicians
(1) Supervising faculty physicians in a teaching hospital may not bill the Office of Medical Assistance Programs (OMAP) on a CMS-1500 or 837P when serving as an employee of the hospital during the time the service was provided or when the hospital reports the service as a direct medical education cost on the Medicare and OMAP cost report.
(2) For requirements for the provision of services, including documentation requirements, follow Medicare guidelines for Teaching Physician Services.
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

410-130-0240
Medical Services
(1) All medical and surgical services requiring prior authorization (PA) are listed in OAR 410-130-0200 PA Table 130-0200-1, and services that are Not Covered/Bundled services are listed in OAR 410-130-0220 Table 130-0220-1. Table 130-0220-1 only contains clarification regarding some services that are not covered. Refer to the Health Services List of Prioritized Services for additional information regarding not covered services.
(2) Acupuncture may be performed by a physician, a physician's employee-acupuncturist under the physician's supervision, or a licensed acupuncturist, and billed using CPT 97810-97814.
(3) Chiropractic services must be billed using 99202 and 99212 for the diagnostic visits and 98940-98942 for manipulation. Use CPT lab and radiology codes which most accurately identify the services performed.
(4) Maternity Care and Delivery:
(a) Use Evaluation and Management codes when providing three or fewer antepartum visits;
(b) For births performed in a clinic or home setting, use CPT codes that most accurately describe the services provided. HCPCS supply code S8415 may be billed in addition to the CPT procedure code. Code S8415 includes all supplies, equipment, staff assistance, birthing suite, newborn screening cards, topical and local anesthetics. Bill medications (except topical and local anesthetics) with HCPCS codes that most accurately describe the medications;
(c) For labor management only, bill 59899 and attach a report;
(d) For multiple births, bill the highest level birth with the appropriate CPT code and the other births under the delivery only code. For example, for total OB with cesarean delivery of twins, bill 59510 for the first delivery and 59514 for the second delivery.
(5) Mental Health and Psychiatric Services:
(a) For Administrative Exams and reports for psychiatric or psychological evaluations, refer to the Administrative Exam rules;
(b) Psychiatrists can be reimbursed by OMAP for symptomatic diagnosis and services, which are somatic (physical) in nature. Contact the local Mental Health Department for covered psychiatric and psychological services;
(c) Mental Health Services – Must be provided by local Mental Health Clinics or a client's Mental Health Organization (MHO). Not payable to private physicians, psychologists, and social workers.
(6) Neonatal Intensive Care Unit (NICU) procedure codes:
(a) Are reimbursed only to neonatologists and pediatric intensivists for services provided to infants when admitted to a Neonatal or Pediatric Intensive Care Unit (NICU/PICU). All other pediatricians must use other CPT codes when billing for services provided to neonates and infants;
(b) Consultations by specialists other than neonatologists and pediatric intensivists are payable in addition to these codes;
(c) Neonatal intensive care codes are not payable for infants on Extracorporeal Membrane Oxygenation (ECMO). Use specific CPT ECMO codes.
(7) Neurology/Neuromuscular–Payment for polysomnographs and multiple sleep latency test (MSLT) are each limited to two in a 12-month period.
(8) Ophthalmology Services–Routine eye exams for the purpose of glasses or contacts are limited to one examination every 24 months for adults. All materials and supplies must be obtained from OMAP's contractor. Refer to the Vision Program Rules for more information.
(9) Speech & Hearing:

(a) HCPCS codes V5000-V5299 are limited to speech-language pathologists, audiologists, and hearing aid dealers;
(b) Refer to the Speech and Hearing Program Rules for detailed information;
(c) Payment for hearing aids and speech therapy must be authorized before the service is delivered;
(d) CPT 92593 and 92595 are only covered for children under age 21.
(10) Massage therapy is covered only when provided with other modalities during the same physical therapy session. Refer to Physical and Occupational Therapy Services administrative rules (Chapter 410 Division 131) for other restrictions.
Statutory Authority: ORS Chapter 409
Statutes Implemented: 414.065

410-130-0255
Immunizations and Immune Globulins
(1) Use standard billing procedures for vaccines that are not part of the Vaccines for Children (VFC) Program.
(2) The Office of Medical Assistance Programs (OMAP) covers Synagis (palivizumab-rsv-igm) only for high-risk infants and children as defined by the American Academy of Pediatric guidelines. Bill 90378 for Synagis.
(3) Providers are encouraged to administer combination vaccines when medically appropriate and cost effective.
(4) VFC Program:
(a) Under this federal program, vaccine serums are free for clients ages 0 through 18. OMAP will not reimburse the cost of privately purchased vaccines that are provided through the VFC Program, but will reimburse for the administration of those vaccines;
(b) Only providers enrolled in the VFC Program can receive free vaccine serums. To enroll as a VFC provider, contact the Public Health Immunization Program. For contact information, see the Medical-Surgical Supplemental Information;
(c) OMAP will reimburse providers for the administration of any vaccine provided by the VFC Program. Whenever a new vaccine becomes available through the VFC Program, administration of that vaccine is also covered by OMAP;
(d) Refer to Table 130-0255-1 for immunization codes provided through the VFC Program. Recommendations as to who may receive influenza vaccines vary from season to season and may not be reflected in Table 130-0255-1;
(e) Use the following procedures when billing for the administration of a VFC vaccine:
(A) When the sole purpose of the visit is to administer a VFC vaccine, the provider should bill the appropriate vaccine procedure code with modifier -26 or -SL for each injection. Do not bill CPT code 90465-90474 or 99211;
(B) When the vaccine is administered as part of an Evaluation and Management service (e.g., well-child visit) the provider should bill the appropriate immunization code with modifier -26, or -SL for each injection in addition to the Evaluation and Management code.
Table 130-0255-1
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

Table 130-0255-1 Vaccines for Children

90632 (*1)	90707
90633	90710
90636 (*1)	90713
90645	90714
90647-90648	90715
90655 (*2)	90716
90656 (*3)	90721 (*4)
90657 (*2)	90723
90658 (*3)	90732
90660 (*5)	90733
90680	90734
90669	90744
90700	90746 (*1)
90702	90748

Age 18 only.
All children ages 6-35 months.
All children ages 36-59 months and all medically high-risk children ages 60 months through 18 years as defined by the Public Health Immunization Program, including contacts to high-risk household members.
Use when 90700 and 90648 are given combined in one injection.
All children ages 5 through 18 who are contacts to high-risk household members, as defined by the Public Health Immunization Program.

410-130-0580
Hysterectomies and Sterilization
(1) Refer to OAR 410-130-0200 Prior Authorization, Table 130-0200-1 and OAR 410-130-0220 Not Covered/Bundled Services, Table 130-0220-1.
(2) Hysterectomies performed for the sole purpose of sterilization are not covered.
(3) All hysterectomies, except radical hysterectomies, require prior authorization (PA).
(4) A properly completed Hysterectomy Consent form (OMAP 741) or a statement signed by the performing physician, depending upon the following circumstances, is required for all hysterectomies:
(a) When a woman is capable of bearing children:
(A) Prior to the surgery, the person securing authorization to perform the hysterectomy must inform the woman and her representative, if any, orally and in writing, that the hysterectomy will render her permanently incapable of reproducing;
(B) The woman or her representative, if any, must sign the consent form to acknowledge she received that information.
(b) When a woman is sterile prior to the hysterectomy, the physician who performs the hysterectomy must certify in writing that the woman was already sterile prior to the hysterectomy and state the cause of the sterility;
(c) When there is a life-threatening emergency situation that requires a hysterectomy in which the physician determines that prior acknowledgment is not possible, the physician performing the hysterectomy must certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible and describe the nature of the emergency.
(5) In cases of retroactive eligibility:
(a) The physician who performs the hysterectomy must certify in writing one of the following:
(A) The woman was informed before the operation that the hysterectomy would make her permanently incapable of reproducing;
(B) The woman was previously sterile and state the cause of the sterility;
(C) The hysterectomy was performed because of a life-threatening emergency situation in which prior acknowledgment was not possible and describe the nature of the emergency.
(b) Additional supplies of the Hysterectomy Consent form (OMAP 741) may be obtained through the DHS Distribution Center.
(6) Do not use the Consent to Sterilization form (OMAP 742) for hysterectomies.
(7) Mail a copy of the Hysterectomy consent form to the Office of Medical Assistance Programs (OMAP).
(8) Do not submit a copy of the Hysterectomy consent form with the claim.
(9) Sterilization Male & Female: A copy of a properly completed Consent to Sterilization form (OMAP 742), the consent form in the federal brochure DHHS Publication No. (05) 79-50062 (Male), DHHS Publication No. (05) 79-50061 (Female) or another federally approved form must be submitted to OMAP for all sterilization. The original consent form must be retained in the clinical records. Prior authorization is not required.
(10) Voluntary Sterilization:
(a) Consent for sterilization must be an informed choice. The consent is not valid if signed when the client is:
(A) In labor;

(B) Seeking or obtaining an abortion; or
(C) Under the influence of alcohol or drugs.
(b) Ages 15 years or older who are mentally competent to give informed consent:
(A) At least 30 days, but not more than 180 days, must have passed between the date of the informed written consent (date of signature) and the date of the sterilization except:
(i) In the case of premature delivery by vaginal or cesarean section the consent form must have been signed at least 72 hours before the sterilization is performed and more than 30 days before the expected date of confinement;
(ii) In cases of emergency abdominal surgery (other than cesarean section), the consent form must have been signed at least 72 hours before the sterilization was performed.
(B) The client must sign and date the consent form before it is signed and dated by the person obtaining the consent. The date of signature must meet the above criteria. The person obtaining the consent must sign the consent form anytime after the client has signed but before the date of the sterilization. If an interpreter is provided to assist the individual being sterilized, the interpreter must also sign the consent form on the same date as the client;
(C) The client must be legally competent to give informed consent. The physician performing the procedure, and the person obtaining the consent, if other than the physician, must review with the client the detailed information appearing on the Consent to Sterilization form regarding effects and permanence of the procedure, alternative birth control methods, and explain that withdrawal of consent at any time prior to the surgery will not result in any loss of other program benefits.
(11) Involuntary Sterilization -- Clients who lack the ability to give informed consent and are 18 years of age or older:
(a) Only the Circuit Court of the county in which the client resides can determine that the client is unable to give informed consent;
(b) The Circuit Court must determine that the client requires sterilization;
(c) When the court orders sterilization, it issues a Sterilization Order. The order must be attached to the billing invoice. No waiting period or additional documentation is required.
(12) Submitting the Consent to Sterilization Form:
(a) After the sterilization is performed, a copy of the completed Consent to Sterilization form (OMAP 742) should be mailed by the performing surgeon to OMAP;
(b) OMAP will review the form for errors and either call the provider or mail the form back if there are discrepancies.
(c) The Consent to Sterilization form must be completed in full:
(A) Consent forms submitted to OMAP without signatures and/or dates of signature by the client or the person obtaining consent are invalid;
(B) The client and the person obtaining consent may not sign or date the consent retroactively;
(C) The performing physician must sign the consent form. The date of signature must be either the date the sterilization was performed or a date following the sterilization.
(d) Do not submit the OMAP 742 with the claim;
(13) Initial claims by the surgeon, anesthesiologist and hospital will be paid without review of the consent form. OMAP will review all sterilization claims during a post-payment audit. If the OMAP 742 is missing or invalid, OMAP will recoup payments directly related to the sterilization from the surgeon, anesthesiologist and hospital.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

410-130-0585
Family Planning Services
(1) Family planning services are those intended to prevent or delay pregnancy, or otherwise control family size.
(2) The Office of Medical Assistance Programs (OMAP) covers family planning services for clients of childbearing age (including minors who are considered to be sexually active).
(3) Family Planning services include:
(a) Annual exams;
(b) Contraceptive education and counseling to address reproductive health issues;
(c) Laboratory tests;
(d) Radiology services;
(e) Medical and surgical procedures, including tubal ligations and vasectomies;
(f) Pharmaceutical supplies and devices.
(4) Clients may seek family planning services from any provider enrolled with OMAP, even if the client is enrolled in a Prepaid Health Plan (PHP). Reimbursement for family planning services is made either by the client's PHP or OMAP. If the provider is:
(a) A participating provider with the client's PHP, bill the PHP;
(b) An enrolled OMAP provider, but is not a participating provider with the client's PHP, bill OMAP and mark the family planning box (24H) with a "Y" on the CMS-1500 claim form or 837P.
(5) Family planning methods include natural family planning, abstinence, intrauterine device, cervical cap, prescriptions, sub-dermal implants, condoms, and diaphragms.
(6) Bill all family planning services with the most appropriate ICD-9-CM diagnosis code in the V25 series (Contraceptive Management), the most appropriate CPT or HCPCS code and add modifier –FP.
(7) For annual family planning visits use the appropriate CPT code in the Preventative Medicine series (9938X-9939X). These codes include comprehensive contraceptive counseling.
(8) When comprehensive contraceptive counseling is the only service provided at the encounter, use a CPT code from the Preventative Medicine, Individual Counseling series (99401-99404).
(9) Bill contraceptive supplies with the most appropriate HCPCS codes.
(10) Where there are no specific CPT or HCPCS codes, use an appropriate unlisted code and add modifier -FP. Bill supplies at acquisition cost.
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

410-130-0587
Family Planning Clinic Services
(1) This rule pertains only to Family Planning Clinics.
(2) To enroll with the Office of Medical Assistance Programs (OMAP) as a Family Planning Clinic, a provider must also be enrolled with the Office of Family Health as a Family Planning Expansion Project (FPEP) provider.
(3) Family Planning Clinics must follow all applicable FPEP and OMAP rules.
(4) OMAP will reimburse Family Planning Clinics an encounter rate only when the primary purpose of the visit is for family planning.
(5) Bill HCPCS code T1015 "Clinic visit/encounter, all-inclusive; family planning" for all encounters where the primary purpose of the visit is contraceptive in nature:
(a) This encounter code includes the visit and any procedure or service performed during that visit including:
(A) Annual family planning exams;
(B) Family planning counseling;
(C) Insertions and removals of implants and IUDs;
(D) Diaphragm fittings;
(E) Dispensing of contraceptive supplies and contraceptive medications;
(F) Contraceptive injections.
(b) Do not bill procedures, such as IUD insertions, diaphragm fittings or injections, with CPT or HCPCS codes;
(c) Bill only one encounter per date of service;
(d) Reimbursement for educational materials is included in T1015. Educational materials are not billable separately.
(6) Reimbursement for T1015 does not include payment for family planning (FP) supplies and medications:
(a) Bill contraceptive supplies and contraceptive medications separately using HCPCS codes. Where there are no specific HCPCS codes, use an appropriate unspecified HCPCS code:
(A) Bill spermicide code A4269 per tube;
(B) Bill contraceptive pills code S4993 per monthly packet;
(C) Bill emergency contraception with code S4993 and bill per packet.
(b) Bill all contraceptive supplies and contraceptive medications at acquisition cost;
(c) Add modifier -FP after all codes for contraceptive services, supplies and medications;
(d) Non-contraceptive medications are not billable under this program.
(7) Reimbursement for T1015 does not include payment for laboratory tests:
(a) Clinics and providers who perform lab tests in their clinics and are CLIA certified to perform those tests may bill CPT and HCPCS lab codes in addition to T1015;
(b) Add modifier -FP after lab codes to indicate that the lab was performed during an FP encounter;
(c) Labs sent to outside laboratories, such as PAP smears, can be billed only by the performing laboratory.
(8) Encounters where the primary purpose of the visit is not contraceptive in nature, use appropriate CPT codes and do not add modifier -FP.
(9) When billing for services provided to clients enrolled in a Prepaid Health Plan, mark the family planning Box 24 H on the CMS-1500 billing form or 837P.
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

410-130-0595
Maternity Case Management (MCM)
(1) The primary purpose of the MCM program is to optimize pregnancy outcomes including reducing the incidence of low birth weight babies. MCM services are tailored to the individual client needs. These services are provided face-to-face, unless specifically indicated in this rule, throughout the client's pregnancy.
(2) This program:
(a) Is available to all pregnant clients receiving Medical Assistance Program coverage;
(b) Expands perinatal services to include management of health, economic, social and nutritional factors through the end of pregnancy and a two-month postpartum period;
(c) Must be initiated during the pregnancy and before delivery;
(d) Is an additional set of services over and above medical management of pregnant clients;
(e) Allows for billing for intensive nutritional counseling services.
(3) Any time there is a significant change in the health, economic, social, or nutritional factors of the client, the prenatal care provider must be notified.
(4) In situations where multiple providers are seeing one client for MCM services, the case manager must coordinate care to ensure duplicate claims are not submitted to the Office of Medical Assistance Programs (OMAP) if services are duplicated.
(5) Definitions:
(a) Case Management -- An ongoing process to assist the individual client in obtaining access to and effective utilization of necessary health, social, economic, nutritional, and other services as defined in the Client Service Plan (CSP) or other documentation;
(b) Case Management Visit -- A face-to-face encounter between a maternity case manager and the client that must include two or more specific training and education topics, addresses the CSP and provides on-going relationship development between the client and the case manager;
(c) Client Service Plan (CSP) -- A written systematic, client coordinated plan of care which lists goals and actions required to meet the needs of the client as identified in the Initial Assessment and includes a client discharge plan/summary;
(d) High Risk Case Management -- Intensive case management services provided to a client identified and documented by the maternity case manager or prenatal care provider as being high risk;
(e) High Risk Client -- Includes clients who have current (within the last year) documented alcohol, tobacco or other drug (ATOD) abuse history, or who are 17 or under, or have other conditions identified in the initial assessment or during the course of service delivery;
(f) Home/Environmental Assessment -- A visit to the client's primary place of residence to assess health and safety of the client's living conditions;
(g) Initial Assessment -- Documented, systematic collection of data with planned interventions as outlined in a CSP to determine current status and identify needs and strengths, in physical, psychosocial, behavioral, developmental, educational, mobility, environmental, nutritional, and emotional areas;
(h) Nutritional Counseling -- Intensive nutritional counseling for clients who have at least one of the conditions listed under Nutritional Counseling (14);

(i) Prenatal/Perinatal Care Provider -- The physician, licensed physician assistant, nurse practitioner, certified nurse midwife, or licensed direct entry midwife providing prenatal or perinatal (including labor and delivery) and/or postnatal services to the client;
(j) Telephone Case Management Visit -- A non-face-to-face encounter between a maternity case manager and the client providing identical services of a Case Management Visit (G9012).
(6) Maternity Case Manager Qualifications:
(a) Maternity case managers must be currently licensed as a:
(A) Physician;
(B) Physician Assistant;
(C) Nurse Practitioner;
(D) Certified Nurse Midwife;
(E) Direct Entry Midwife;
(F) Social Worker; or
(G) Registered Nurse.
(b) All of the above must have a minimum of two years related and relevant work experience;
(c) Other paraprofessionals may provide specific services with the exclusion of the initial assessment (G9001) while working under the supervision of one of the practitioners listed in (6)(a)(A-G) of this rule;
(d) Specific services not within the recognized scope of practice of the provider of MCM services must be referred to an appropriate discipline.
(7) Nutritional Counselor Qualifications -- Nutritional counselors must:
(a) Be a registered dietician; or
(b) Have a bachelor's degree in a nutrition-related field with two years of related work experience.
(8) Documentation Requirements:
(a) Documentation is required for all MCM services in accordance with OMAP General Rules 410-120-1360; and
(b) A correctly completed OMAP form 2470, 2471, 2472 and 2473 or their equivalents meet minimum documentation requirements for Maternity Case Management Services.
(9) G9001 -- Initial Assessment must be performed by a licensed Maternity Case Manager as defined under (6) (a):
(a) Services include:
(A) Client assessment as outlined in the "Definitions" section of this rule;
(B) Development of a CSP which addresses needs identified;
(C) Making and assisting with referrals as needed to:
(i) A prenatal care provider;
(ii) A dental health provider.
(D) Forwarding the initial assessment and other relevant information to the prenatal care provider;
(E) Communicating pertinent information to others participating in the client's medical and social care.
(b) Data sources relied upon may include:
(A) Initial assessment;
(B) Client interviews;

(C) Available records;
(D) Contacts with collateral providers;
(E) Other professionals; and
(F) Other parties on behalf of the client.
(c) The client's record must reflect the date and to whom the initial assessment was sent;
(d) Billable once per pregnancy per provider. No other MCM service can be performed until after an initial assessment has been completed. No other maternity management codes except a Home/Environmental Assessment (G9006) and a Case Management Visit (G9012) may be billed the same day as an initial assessment.
(10) G9002 -- Case Management (Full Service) -- Includes:
(a) Face-to-face client contacts;
(b) Implementation and monitoring of a CSP:
(A) The client's records must include a CSP and written updates to the plan;
(B) The CSP activities involve determining the client's strengths and needs, setting specific goals and utilizing appropriate resources in a cooperative effort between the client and the maternity case manager.
(c) Referral to services included in the CSP:
(A) Make referrals, provide information and assist the client in self-referral;
(B) Maintain contact with resources to ensure service delivery, share information, and assist with coordination.
(d) Ongoing nutritional evaluation with basic counseling and referrals to nutritional counseling, as indicated;
(e) Utilization and documentation of the "5 A's" brief intervention protocol for addressing tobacco use (US Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence, 2000). Routinely:
(A) Ask all MCM clients about smoking status;
(B) Advise all smoking clients to quit;
(C) Assess for readiness to try to quit;
(D) Assist all those wanting to quit by referring them to the Quitline and/or other appropriate tobacco cessation counseling and provide motivational information for those not ready to quit;
(E) Arrange follow-up for interventions.
(f) Provide training and education on all mandatory topics - Refer to Table 130-0595-2;
(g) Provide linkage to labor and delivery services;
(h) Provide linkage to family planning services as needed;
(i) CSP coordination as follows:
(A) Contact with Department of Human Services worker, if assigned;
(B) Contact with prenatal care provider;
(C) Contact with other community resources/agencies to address needs.
(j) Client advocacy as necessary to facilitate access. The case manager serves as a client advocate and intervenes with agencies or persons to help the client receive appropriate benefits or services;
(k) Assist client in achieving the goals in the CSP. The case manager will advocate for the client when resources are inadequate or the service delivery system is non-responsive;
(l) Billable once per pregnancy.

(m) Billable after the delivery when more than three months of service were provided. Services must be initiated during the prenatal period and carried through the date of delivery.
(11) G9009 -- Case Management (Partial Service):
(a) Can be billed when the CSP has been developed and case management services (G9002) were initiated during the prenatal period and partially completed;
(b) Provided case management services to the client for three months or less.
(12) G9005 -- High Risk Case Management (Full Service):
(a) Enhanced level of services which are more intensive and are provided in addition to G9002;
(b) Provided at least eight Case Management Visits;
(c) Provided high risk case management services to the client for more than three months;
(d) Billable after the delivery and only once per pregnancy;
(e) Can be billed in addition to G9002.
(13) G9010 -- High Risk Case Management (Partial Service):
(a) Are the same enhanced level of services provided in G9005 but the client became "high risk" during the latter part of the pregnancy or intensive high risk MCM services were initiated and partially completed but not carried through to the date of delivery;
(b) Provided less than eight Case Management Visits;
(c) Provided high risk case management services to the client for three months or less;
(d) Billable after the delivery and once per pregnancy;
(e) Can be billed in addition to G9002 or G9009.
(14) S9470 -- Nutritional Counseling:
(a) Available for clients who have at least one of the following conditions:
(A) Chronic disease such as diabetes or renal disease;
(B) Hematocrit (Hct) less than 34 or hemoglobin (Hb) less than 11 during the first trimester, or Hct less than 32 or Hb less than 10 during the second or third trimester;
(C) Pre-gravida weight under 100 pounds or over 200 pounds;
(D) Pregnancy weight gain outside the appropriate WIC guidelines;
(E) Eating disorder;
(F) Gestational diabetes;
(G) Hyperemesis;
(H) Pregnancy induced hypertension (pre-eclampsia); or
(I) Other conditions identified by the maternity case manager, physician or prenatal care provider for which adequate services are not accessible through another program.
(b) Documentation must include all of the following:
(A) Nutritional assessment;
(B) Nutritional care plan;
(C) Regular client follow-up.
(c) Can be billed in addition to other MCM services;
(d) Billable once per pregnancy.
(15) G9006 -- Home/Environment Assessment:
(a) Includes an assessment of the health and safety of the client's living conditions with training and education of all topics as indicated in Table 130-0595-1;
(b) One Home/Environment Assessment may be billed per pregnancy. Additional Home/Environment Assessments may be billed with documentation of problems which

(b) One Home/Environment Assessment may be billed per pregnancy. Additional Home/Environment Assessments may be billed with documentation of problems which necessitate a follow-up assessment or when a client moves. Documentation must be submitted with the claim to support the additional home/environment assessment.
(16) G9011 -- Telephone Case Management Visit:
(a) A non-face-to-face encounter between a maternity case manager and the client, meeting all requirements of a Case Management Visit (G9012) and when a face-to-face Case Management Visit is not possible or practical;
(b) In lieu of a Case Management visit and counted towards the total number of Case Management Visits (see G9012 for limitations).
(17) G9012 -- Case Management Visit:
(a) Each Case Management Visit must include an evaluation and/or revision of objectives and activities addressed in the CSP and at least two training and education topics listed in Table 130-0595-2;
(b) Four Case Management Visits may be billed per pregnancy. Telephone contacts (G9011) are included in this limitation;
(c) Six additional Case Management Visits may be billed if the client is identified as High Risk. These additional visits may not be billed until after delivery. Bills for these additional six visits may only be submitted with or after High-Risk Full (G9005) or Partial (G9010) case management has been billed. Telephone contacts (G9011) are included in this limitation;
(d) May be provided in the client's home or other site.
Table 130-0595-1
Table 130-0595-2
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

Table 130-0595-1 Environmental Assessment

General Assessment
General Condition of House
Adequacy of Shelter
Food Storage Facilities
Food Preparation Facilities
Health Adequacy: Safety and sanitation
Heating/Cooling/Ventilation
Number of bedrooms vs. number of persons
Running Water
Phone Service
Sanitation/Sewer
Environmental Hazards
Toxins/Teratogens
Safety
Guns: Locked and Unloaded
Smoke Alarm: Installed & Working
Fire Prevention: i.e., smoking habits, if applicable
Adequate Exits: All locations & free of obstacles
Toxins
Lead Exposure: Peeling paint, lead pipes & lead dust
Chemical Use: In or near home
Asbestos
Pets
Cats (Toxoplasmosis)
Birds (Psittacosis)
Reptiles (Salmonella), i.e., iguanas, turtles, snakes

Table 130-0595-2 MCM Training and Education Topics

Mandatory Topics:
Maternal/Fetal HIV Transmission
Fetal Alcohol Syndrome
Prevention of Early Childhood Caries
Maternal Oral Health
Tobacco Use/Exposure-use of "5 A's"
Lead Exposure and Screening
Immunizations

Other Topics:

Pre-term Birth Prevention
Factors associated with increased risk
Early detection of symptoms
Obtaining help-information
Stress reduction

Pregnancy & Childbirth
Common discomforts
Pregnancy danger signs & symptoms
Labor and birth process
Coping strategies
Common interventions
Emergencies

Health Status
Rest/exercise
Digestive tract changes
Weight gain
Food availability
Food selection/preparation
Nutrition
Nutrient/calorie intake
Medications

Environment
Health Adequacy
Safety and Sanitation
Environmental Hazards
Toxins/Teratogens
  Mercury consumption from eating fish
Fluoridated Water Area

Emotional
Stress reduction
Coping strategies
Hormonal changes
Relationships

Other
Family planning
Sexually Transmitted Diseases
Substance/alcohol use

Infant Care/Parenting
Feeding/nutrition/infant growth
Clothing needs
Infant sleep patterns and location
Wellness care/immunizations
Breastfeeding
SIDS and BackTo Sleep
Developmental milestones
Common interventions
Emergencies
Safety
Infant/parent interaction
Bonding/attachment
Infant communication patterns/cues
Parental frustration/sleep deprivation
Household management support
Community resources
Child nurturing/protection

410-130-0670
Death with Dignity
(1) All Death with Dignity services must be billed directly to the Office of Medical Assistance Programs (OMAP), even if the client is in a managed care plan.
(2) Death with Dignity is a covered service, incorporated in the "comfort care" condition/treatment line on the Health Services Commission's Prioritized List of Health Services.
(3) The following physician visits and medical encounters are billable when performed by a licensed physician or psychologist:
(a) The medical confirmation of the terminal condition;
(b) The two visits in which the client makes the oral request;
(c) The visit in which the written request is made;
(d) The visit in which the prescription is written;
(e) Counseling consultation(s); and
(f) Medication and dispensing.
(4) More than one of the services listed in sections (3)(a) through (3)(f) may be provided during the same visit. Additional visits for discussion or counseling are also covered for payment.
(5) Billing:
(a) All claims for Death with Dignity services must be made on a paper CMS-1500 billing form;
(b) Do not submit a claim for Death with Dignity services electronically or on an 837P;
(c) Claims must be submitted using appropriate CPT or HCPCS codes;
(d) OMAP unique diagnosis code PAD-00 must be entered in Field 21 of the CMS-1500 billing form. Do not list any additional diagnosis codes in this field;
(e) Claims must be submitted only on paper to: OMAP, PO Box 992, Salem, Oregon 97308-0992;
(f) Prescriptions must be billed only with OMAP unique code 8888-PAID-00. This code must be entered in Field 24D of the CMS-1500. In addition, the actual NDC number of the drug dispensed and the dosage must be listed below the prescription code;
(g) OMAP may be billed for prescription services only when the pharmacy has been properly notified by the physician in accordance with OAR 847-015-0035. This OAR requires the physician to have the client's written consent to contact and inform the pharmacist of the purpose of the prescription.
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

410-130-0680
Laboratory and Radiology
(1) The following tables list the medical and surgical services that:
(a) Require prior authorization (PA) – OAR 410-130-0200 Table 130-0200-1 (PET scans require PA and are included in the table), and;
(b) Require prior notification (PN) – OAR 140-130-0200 Table 130-0200-2 (MRIs, MRAs, CTs, CTAs, and SPECT scans require PN and are included in the table), and;
(c) Are not covered/bundled – OAR 410-130-0220 Table 130-0220-1.
(2) Newborn screening (NBS) kits and collection and handling for newborn screening (NBS) tests performed by the Oregon State Public Health Laboratory (OSPHL) are considered bundled into the delivery fee and, therefore, must not be billed separately. Replacement of lost NBS kits may be billed with code S3620 with modifier –TC. The loss must be documented in the client's medical record. NBS confirmation tests performed by reference laboratories at the request of the OSPHL shall be reimbursed only to the OSPHL.
(3) The Office of Medical Assistance Programs (OMAP) covers lab tests performed in relation to a transplant only if the transplant is covered and if the transplant has been authorized. See the OMAP Transplant Services administrative rules (Chapter 410, Division 124).
(4) All lab tests must be specifically ordered by, or at the direction of a licensed medical practitioner within the scope of their license.
(5) If a lab sends a specimen to a reference lab for additional testing, the reference lab may not bill for the same tests performed by the referring lab.
(6) When billing for lab tests, use the date that the specimen was collected as the date of service (DOS) even if the tests were not performed on that date.
(7) Reimbursement for drawing/collecting or handling samples:
(a) OMAP will reimburse providers once per day regardless of the frequency performed for drawing/collecting the following samples:
(A) Blood – by venipuncture or capillary puncture, and;
(B) Urine – only by catheterization.
(b) OMAP will not reimburse for the collection and/or handling of other specimens, such as PAP or other smears, voided urine samples, or stool specimens. Reimbursement is bundled in the reimbursement for the exam and/or lab procedures and is not payable in addition to the laboratory test.
(8) Pass-along charges from the performing laboratory to another laboratory, medical practitioner, or specialized clinic are not covered for payment and are not to be billed to OMAP.
(9) Only the provider who performs the test(s) may bill OMAP.
(10) Clinical Laboratory Improvement Amendments (CLIA) Certification:
(a) OMAP will only reimburse laboratory services to providers who are CLIA certified by the Centers for Medicare and Medicaid Services (CMS);
(b) CLIA requires all entities that perform even one test, including waived tests on... "materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings" to meet certain Federal requirements. If an entity performs tests for these purposes, it is considered under CLIA to be a laboratory;
(c) Providers must notify OMAP of the assigned ten-digit CLIA number;
(d) Payment is limited to the level of testing authorized by the CLIA certificate at the time the test is performed.
(11) Organ Panels:

(a) OMAP will only reimburse panels as defined by the CPT codes for the year the laboratory service was provided. Tests within a panel may not be billed individually even when ordered separately. The same panel may be billed only once per day per client;
(b) OMAP will pay at the panel maximum allowable rate if two or more tests within the panel are billed separately and the total reimbursement rate of the combined codes exceeds the panel rate, even if all the tests listed in the panel are not ordered or performed.
(12) Radiology:
(a) Provision of diagnostic and therapeutic radionuclide(s), HCPCS A9500-A9699, are payable only when given in conjunction with radiation oncology and nuclear medicine codes 77401-79999;
(b) HCPCS codes R0070 through R0076 are covered.
(13) Reimbursement of contrast and diagnostic-imaging agents is bundled in the radiology procedure except for low osmolar contrast materials (LOCM).
(14) Supply of LOCM may be billed in addition to the radiology procedure only when the following criteria are met:
(a) Prior adverse reaction to contrast material, with the exception of a sensation of heat, flushing or a single episode of nausea or vomiting;
(b) History of asthma or significant allergies;
(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction or pulmonary hypertension;
(d) Decrease in renal function;
(e) Diabetes;
(f) Dysproteinemia;
(g) Severe dehydration;
(h) Altered blood brain barrier (i.e., brain tumor, subarachnoid hemorrhage);
(i) Sickle cell disease, or;
(j) Generalized severe debilitation.
(15) X-ray and EKG interpretations in the emergency room:
(a) OMAP reimburses only for one interpretation of an emergency room patient's x-ray or EKG. The interpretation and report must have directly contributed to the diagnosis and treatment of the patient;
(b) OMAP considers a second interpretation of an x-ray or EKG to be for quality control purposes only and will not be reimbursed;
(c) Payment may be made for a second interpretation only under unusual circumstances, such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed.
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

410-130-0700
HCPCS Supplies and DME
(1) Use appropriate HCPCS codes to bill all supplies and DME.
(2) For items that do not have specific HCPCS codes:
(a) Use unlisted HCPCS code;
(b) Bill at acquisition cost, purchase price plus postage.
(3) CPT code 99070 is no longer billable for supplies and materials. Use HCPCS codes.
(4) Use S3620 with modifier TC for lost newborn screening (NBS) kits.
(5) The Office of Medical Assistance Programs (OMAP) bundles reimbursement for office surgical suites and office equipment in the reimbursement of surgical procedures.
(6) Contraceptive Supplies--Refer to OAR 410-130-0585.
(7) A4000-A9999:
(a) All "A" codes listed in Table 130-0700-1 are covered under this program;
(b) All "A" codes not listed in Table 130-0700-1 must be referred to a Durable Medical Equipment (DME) provider;
(c) Do not use A4570, A4580 and A4590 for splint and cast materials. Use codes Q4001-Q4051;
(d) A9150-A9999 (administrative, investigational, and miscellaneous) are not covered, except for A9500-A9699. Refer to OAR 410-130-0680.
(8) B4000-B9999:
(a) HCPCS codes B4034-B4036 and B4150-B9999 are not covered for medical-surgical providers;
(b) Refer these services to home enteral/parenteral providers.
(9) C1000-C9999 are not covered.
(10) E0100-E1799: OMAP covers only the following DME HCPCS codes for medical-surgical providers when provided in an office setting:
(a) E0100-E0116;
(b) E0602;
(c) E0191;
(d) E1399;
(e) Refer all other items with "E" series HCPCS codes to DME providers.
(11) J0000-J9999 HCPCS codes--Refer to OAR 410-130-0180 for coverage of drugs.
(12) K0000-K9999 HCPCS codes--Refer all items with "K" series to DME providers.
(13) L0000-L9999:
(a) Refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies program Administrative rules for coverage criteria for orthotics and prosthetics;
(b) Refer to Table 130-0220-1 for a list of "L" codes that are not covered;
(c) Reimbursement for orthotics is a global package, which includes:
(A) Measurements;
(B) Moldings;
(C) Orthotic items;
(D) Adjustments;
(E) Fittings;
(F) Casting and impression materials.
(d) Evaluation and Management codes are covered only for the diagnostic visit where the medical appropriateness for the orthotic is determined and for follow-up visits unrelated to the fitting of the orthotic.
(14) Refer to Table 130-0700-1 for supplies and DME covered in the office setting.
Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Table 130-0700-1 Supplies and DME Covered in Office Setting

A4220
A4260-A4263
A4266-A4269
A4300
A4305-A4320
A4322-A4328
A4330-A4331
A4333-A4346
A4348-A4362
A4367
A4369
A4371-A4373
A4375-A4385
A4387-A4399
A4404-A4421
A4462-A4465
A4550
A4561-A4562
A4565
A4649
A5051-A5112
A5500-A5507
A5509-A5511
A6010-A6011
A6021-A6224
A6231-A6248
A6251-A6259
A6261-A6262
A6266-A6404
A6421-A6438
B4081-B4083
B4086
E0100-E0116
E0191
E0602
E1399