6-13

Secretary of State
Certificate and Order for Filing

PERMANENT ADMINISTRATIVE RULES

I certify that the attached copies* are true, full and correct copies of the PERMANENT Rule(s) adopted on 6/6/08 by the
Date prior to or same as filing date

Department of Human Services (DHS) , Division of Medical Assistance Programs (DMAP) 410
Agency and Division — Administrative Rules Chapter Number

DMAP 20-2008

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to become effective 7/1/2008. Rulemaking Notice was published in the 5/1/2008 *Oregon Bulletin.***
Date upon filing or later — Month and Year

RULEMAKING ACTION

Rule Filing Caption: July 2008-Clarify policies & procedures/ technical changes due to CPT code updates

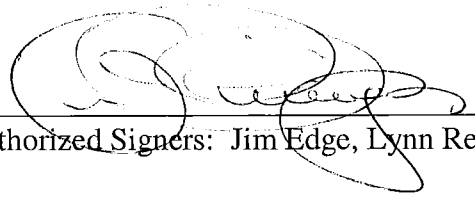
AMEND: 410-130-0000, 410-130-0180, 410-130-0190, 410-130-0200, 410-130-0220, 410-130-0255, 410-130-0610 and 410-130-0680

Statutory Authority: 404.110, 409.050 and 414.065
Other Authority: None
Statutes Implemented: 414.065

FILED
JUN 13 2008
ARCHIVES DIVISION
SECRETARY OF STATE

RULE SUMMARY

The Medical-Surgical Services program administrative rules govern Division of Medical Assistance Programs' (DMAP) payment for services to certain clients. DMAP amended rules listed above to clarify current policies and procedures to ensure Oregon Administrative Rules are not open to interpretation by providers or outside parties and to help eliminate confusion possibly resulting in non-compliance. Amendments to 410-130-0180, 410-130-0190, 410-130-0200, 410-130-0220, 410-130-0255, and 410-130-0680 update CPT code changes, remove prior notification requirements, and make minor internal operational changes pertaining to reimbursement. Having temporarily amended 410-130-0610, DMAP permanently amends the rules to reflect the advancement of telemedicine technology and evidence based medicine research related to the telephonic and e-visit coverage in the HSC and its practice guidelines. Text may be revised to improve readability and take care of necessary "housekeeping" corrections.



6-6-08

Authorized Signers: Jim Edge, Lynn Read or Jean Phillips — Date

410-130-0000
Foreword
(1) The Division of Medical Assistance Programs (DMAP) Medical-Surgical Services rules are designed to assist medical-surgical providers to deliver medical services and prepare health claims for clients with Medical Assistance Program coverage. Providers must follow the DMAP rules in effect on the date of service.
(2) DMAP enrolls only the following types of providers as performing providers under the Medical-Surgical program:
(a) Doctors of medicine, osteopathy and naturopathy;
(b) Podiatrists;
(c) Acupuncturists;
(d) Licensed Physician assistants;
(e) Nurse practitioners;
(f) Laboratories;
(g) Family planning clinics;
(h) Social workers (for specified services only);
(i) Licensed Direct entry midwives;
(j) Portable x-ray providers;
(k) Ambulatory surgical centers;
(l) Chiropractors;
(m) Licensed Dieticians (for specified service only);
(n) Registered Nurse First Assistants;
(o) Certified Nurse Anesthetists;
(p) Clinical Pharmacists.
(3) For clients enrolled in a managed care plan, contact the client's plan for coverage and billing information.
(4) The Medical-Surgical Services rules contain information on policy, special programs, prior authorization, and criteria for some procedures. All DMAP rules are intended to be used in conjunction with the General Rules for Oregon Medical Assistance Programs (OAR 410 Division 120) and the Oregon Health Plan (OHP) Administrative Rules (OAR 410 Division 141).
(5) The Health Services Commission's Prioritized List of Health Services is found on their website at: http://www.oregon.gov/OHPPR/HSC/
Stat. Auth.: ORS 404.110, 409.050, 414.065
Stats. Implemented: ORS 414.065

410-130-0180
Drugs
(1) The Division of Medical Assistance Programs' (DMAP) Medical-Surgical Services Program reimburses practitioners for drugs only when administered by the practitioner in the office, clinic or home settings. DMAP 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-J1817;
(B) J3490;
(C) J3950
(D) J7699;
(E) J7799;
(F) J8499;
(G) J8999
(H) J9999;
(I) 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) DMAP 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 (J7319).
(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 Drug Rebate 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 404.110, 409.050, 414.065
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 using;
(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, less than 6 minutes, 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 is 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, six minutes or greater.
(6) Telephone calls: DMAP may reimburse a telephone call intended as a replacement for face-to-face contact with clients who are in intensive treatment as it is considered a reasonable adjunct to, or replacement for, scheduled counseling sessions:
(a) The call must last six to ten minutes and provides support and follow-up counseling;
(b) The call must 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 does not limit or prescribe services a Prepaid Health Plan provides to clients receiving the Basic Health Care Package.
Stat. Auth.: ORS 404.110, 409.050, 414.065
Stats. Implemented: ORS 414.065

410-130-0200
Prior Authorization
(1) For services provided to clients enrolled in a prepaid health plan (PHP), providers must obtain prior authorization (PA) from the PHP. Contact the PHP for their PA requirements and billing instructions.
(2) PA is not required for services covered by Medicare when the client has both Medicare and Medical Assistance Program coverage. However, PA is required for most transplants, even if they are covered by Medicare.
(3) PA is not required for kidney and cornea transplants unless they are performed out-of-state.
(4) Providers must obtain PA from the Division of Medical Assistance Program's (DMAP) Transplant Coordinator for transplants and non-emergent, non-urgent out-of-state services. Refer to the DMAP Transplant Services rules (Chapter 410, Division 124) for further information on transplants and refer to the DMAP General Rules (Chapter 410, Division 120) for further information concerning out-of-state services.
(5) Providers must obtain PA from the Department of Human Services (DHS) Medically Fragile Children's Unit (MFCU) for services provided to MFCU clients.
(6) Providers must obtain PA from the Case Management Contractor shown on the client's Medical Care ID for services provided to clients enrolled in the fee-for-service (FFS) High Risk Medical Case Managed program.. See the Medical-Surgical Services Supplemental Information guide for details.
(7) PA is required for all procedure codes listed in Table 130-0200-1, in this rule. Providers must obtain PA for these procedures from the Medical-Surgical Prior Authorization contractor) regardless of the setting they are performed in. A second opinion may be requested by DMAP or the contractor before PA is given for a surgery;
(8) PA is not required for hospital admissions unless the procedure requires PA;
(9) PA is not required for emergent or urgent procedures or services;
(10) Providers must obtain PA by the treating and performing practitioners;
(11) Refer to Table 130-0200 for all services/procedures requiring prior authorization.
Table 130-0200
Stat. Auth.: ORS 404.110, 409.010, 414.065
Stats. Implemented: ORS 414.065

Table 130-0200-1 Prior Authorization

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

00580	21280	33944-33945 (*2)
00796	22554	33979
00938	22556	38204-38215 (*2)
11960	22558	38230 (*2)
11970	22585	38240 (*2)
15822	22590	38241 (*2)
15823	22595	40840
17106-17108 (*1)	22600	40842-40845
20910	22610	43631-43634
21050	22612	44135 (*2)
21120	22614	43644-43848
21121	22630	43770-43774
21137-21139	22632	44715-44721 (*2)
21141-21143	22800	47135 (*2)
21145-21147	22802	47136 (*2)47140-
21150	22804	47147 (*2)
21151	22808	48160 (*2)
21154	22810	48551-48552 (*2)
21155	22812	48554 (*2)
21159	22841-22848	48556 (*2)
21160	22851	49000 (*3)
21172	23472	49320
21175	26560-26562	49329
21179-21184	27447	51840
21188	28340	51841
21193-21196	28341	51845
21198	28344	54360
21199	28345	54400
21206	30400	54401
21208	30410	54405
21209	30420	54408
21256	30430	54410
21260	30435	54411
21261	30450	54416
21263	30460	54417
21267	30462	56805
21268	32851-32856 (*2)	57267
21270	33933 (*2)	57283
21275	33935 (*2)	57284

57288	63035	65150
57291	63040	65155
57292	63042-63048	67311 (*4)
57335	63050-63051	67312 (*4)
58150	63055-63057	67314 (*4)
58152	63064	67316 (*4)
58180	63066	67318 (*4)
58260	63075-63078	67320 (*4)
58262-58263	63081	67331 (*4)
58267	63082	67332 (*4)
58270	63085-63088	67334 (*4)
58275	63090	67335 (*4)
58280	63091	67340 (*4)
58285	63101-63103	67550
58290-58294	63170	67560
58400	63172-63173	67900-67904
58410	63180	67906
58541-58544	63182	67908
58548	63185	67909
58550	63190	67911
58552-58554	63191	67912
58660	63194-63200	67914-67917
58661	63250-63252	78459
58672	63265-63268	78491
58673	63270-63273	78492
58720	63275-63278	78608
58940	63280-63283	78609
62351	63285-63287	78811-78816
63001	63290	92507
63003	63295	S2053 (*2)
63005	63300-63308	S2065 (*2)
63011-63012	65125	S2142 (*2)
63015-63017	65130	S2150 (*2)
63020	65135	S2350
63030	65140	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, Division 141) and General Rules (Chapter 410, Division 120) for coverage of services. Refer to Table 130-0220-1, in this rule, for additional information regarding not covered services or for services that are considered by the Division of Medical Assistance Programs (DMAP) 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, maternity case management and telemedicine.
(3) This is not an inclusive list. Specific information is included in the DMAP General Rules, Medical Assistance Benefits: Excluded Services and Limitations (OAR 410-120-1200).
Table 130-0220-1
Stat. Auth.: ORS 404.110, 409.050, 414.065
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	89250-	97010 BND	B4034-
19316	89261	97016	B4036
32850 BND	89264	97018	B4100-
33930 BND	89268	97024	B9999
33940 BND	89272	97026	E Codes (*5)
44132 BND	89280-	97028	G0166
44133	89281	97033	G0219
44136	89290-	97034	G0235
47133BND	89291	90735	G0252
48550 BND	89300	97039	G0370
58740 BND	89310	97139	J7319
74740	89320-	97537	K0000-
74742	89321	97802-	K9999
77422	89325	97804	L1844
77423	89329-	99000-	L2750
78459	89330	99002 BND	L2780
78491	89335	99024	L3251
78492	89342-	99026	L5610
78990 (*1)	89344	99027	L5613-
79900 (*1)	89346	99056	L5614
80414-	89352-	99070 (*1)	L5722
80415	89354	99071 BND	L5724
82757	89356	99075	L5726
84030	92354	99100 BND	L5728
84830	92355	99116 BND	L5780-
86891 BND	92508	99135 BND	L5822
86910-	92559	99140 BND	L5824
86911	92592	99360 (*3)	L5828
88000-	92593	A4570 (*4)	L5830
88099	92595 (*2)	A4580 (*4)	L5848
89235	96150-	A4590 (*4)	L5980
89240	96155	A4641	L5989

L6025
L6310
L6360
L6638
L6646
L6648
L6825
L6875
L6881-
L6882
L6920
L6925
L6930
L6935
L6940
L6945
L6950
L6955
L6960
L6965
L6970
L6975
L7010
L7015
L7020
L7025
L7030
L7035
L7040
L7045
L7170
L7180
L7185-
L7186
L7190-
L7191
L7260-
L7261
L7266
L7272
L7274
L7360
L7362
L7364
L7366-
L7368
L7500
L7520
L7900
L8001-
L8002
L8010
L8035
L8039
L8500-
L8501
L8505
L8507
L8510-
L8514
L8600
L8603
L8606
L8610
L8612-
L8614
L8619
L8630-
L8631
L8641-
L8642
L8658-
L8659
L8670
L8699
L9900
M0075
M0076
M0100
M0300-
M0301
P2028-
P2029
P2031
P2033
P2038
P7001
P9010-
P9012
P9016-
P9023
P9031-
P9048
P9050-
P9060
Q0035
Q0091 BND
Q0092 BND
Q0114-
Q0115
Q9952 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

7-1-07

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 Division of Medical Assistance Programs (DMAP) 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. DMAP 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) DMAP 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 DMAP;
(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 404.110, 409.050, 414.065
Stats. Implemented: ORS 414.065

Table 130-0255-1 Vaccines for Children

~~90632 (*1)~~	90702
90633	90704-8
90634	~~90707~~
~~90636 (*1)~~	90710
90645	90713
90647	90714
90648	90715
90649	90716
90655 (*2)	90721 (*4)
90656 (*3)	90723
90657 (*2)	90732
90658 (*3)	90733
90660 (*5)	90734
90669	90743
90680	90744
~~90669~~	~~90746 (*1)~~
90700	90748

90749 S0195

(*1) Age 18 only.

(*2) All children ages 6-35 months.

(*3) 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.

(*4) Use when 90700 and 90648 are given combined in one injection.

(*5) All children ages 5 through 18 who are contacts to high-risk household members, as defined by the Public Health Immunization Program.

410-130-0610
Telemedicine
(1) For the purposes of this rule, telemedicine is defined as the use of telephonic or electronic communications to medical information from one site to another to improve a patient's health status.
(2) Unless authorized in OAR 410-120-1200 Exclusions, other types of telecommunications are not covered, such as telephone calls, images transmitted via facsimile machines and electronic mail:
(a) When those types are not being used in lieu of videoconferencing, due to limited videoconferencing equipment access, or
(b) When those types and specific services are not specifically allowed in this rule per the Oregon Health Services Commission's Prioritized List of Health Services and Practice Guideline.
(3) Provider Requirements:
(a) The referring and evaluating practitioner must be licensed to practice medicine within the state of Oregon or within the contiguous area of Oregon and must be enrolled as a Division of Medical Assistance Programs (DMAP) provider.
(b) For Addiction and Mental Health Division (AMH) providers, in addition to being enrolled as a DMAP provider under (3) (a). AMH providers must have an AMH agency letter of approval, certification of Approval or license issued by AMH. Individuals must also be providing covered services and be authorized to submit claims for covered telemedicine services under this rule.
(c) Providers billing for covered telemedicine services are responsible for the following:
(A) Complying with Health Insurance Portability and Accountability Act (HIPAA) and DHS Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records. Examples of applicable DHS Confidentiality and Privacy Rules include: OAR 410 Division 14 (DHS Privacy Rules) and 407-014-0300 to 407-014-0320 (Access Control); OAR 407-120-0170, 410-120-1360, and 410-120-1380. Examples of federal and state privacy and security laws that may apply include, if applicable, HIPAA (45 CFR Parts 160, 162, and 164), and 42 CFR Part 2, and ORS 646A.600 to 646A.628 (Oregon Consumer Identity Theft Protection Act);
(B) Obtaining and maintaining technology used in the telemedicine communication that is compliant with privacy and security standards in HIPAA and DHS Privacy and Confidentiality Rules described in subsection (3) (A);
(C) Ensuring policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records (whether oral or recorded in any form or medium) to unauthorized persons;
(D) Complying with the relevant Health Service Commission (HSC) practice guideline for telephone and email consultation. Refer to the current prioritized list and practice guidelines at http://www.oregon.gov/OHPR/HSC/current_prior.shtml;
(E) Maintaining clinical and financial documentation related to telemedicine services as required in OAR 410-120-1360.
(4) Coverage for telemedicine services:
(a) The telemedicine definition encompasses different types of programs, services and delivery mechanisms for medically appropriate covered services within the patient's benefit package;
(b) Patient consultations using telephone and online or electronic mail (e-mail) are covered when billed services comply with the practice guidelines set forth by the Health Service Commission (HSC) and the applicable HSC-approved code requirements, delivered consistent with the HSC practice guideline;

(c) Patient consultations using videoconferencing, a synchronous (live two-way interactive) video transmission resulting in real time communication between a medical practitioner located in a distant site and the client being evaluated and located in an originating site, is covered when billed services comply with the billing requirements stated in below;
(d) Telephonic codes may be used in lieu of videoconferencing codes, if videoconferencing equipment is not available.
(5) Telephone and E-mail billing requirements: Use the Evaluation and Management (E/M) code authorized in the HSC practice guideline, unless otherwise authorized in OAR 410-120-1200.
(6) Videoconferencing billing requirements:
(a) Only the transmission site (where the patient is located) may bill for the transmission:
(A) Bill the transmission with code Q3014;
(B) The referring practitioner may bill an E/M code only if a separately identifiable visit is performed. The visit must meet all of the criteria of the E/M code billed;
(C) The referring provider is not required to be present with the client at the originating site.
(b) The evaluating practitioner at the distant site may bill for the evaluation, but not for the transmission (code Q3014):
(A) Bill the most appropriate E/M code for the evaluation;
(B) Add modifier GT to the E/M code to designate that the evaluation was made by a synchronous (live and interactive) transmission.
(c) In addition, for AMH services specifically identified as allowable for telephonic delivery when appropriate, refer to the procedure code and reimbursement rates published by AMH.
Stat. Auth.: ORS 404.110, 409.050, 414.065
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) 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 will be reimbursed only to the OSPHL.
(3) The Division of Medical Assistance Programs (DMAP) covers lab tests performed in relation to a transplant only if the transplant is covered and if the transplant has been authorized. See the DMAP 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) DMAP 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) DMAP 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 DMAP.
(9) Only the provider who performs the test(s) may bill DMAP.
(10) Clinical Laboratory Improvement Amendments (CLIA) Certification:
(a) DMAP 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 DMAP 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) DMAP 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) DMAP 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) DMAP 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) DMAP 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 404.110, 409.050, 414.065
Stats. Implemented: ORS 414.065