6-12

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 5/27/2009 by the
Date prior to or same as filing date

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

DMAP 18-2009

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to become effective 7/1/2009. Rulemaking Notice was published in the 5/1/2009. *Oregon Bulletin*.**
Date upon filing or later — Month and Year

RULEMAKING ACTION

Rule Filing Caption: July '09, non-substantive revisions for various language and code updates

AMEND: 410-130-0163, 410-130-0180, 410-130-0200, 410-130-0220, 410-130-0240, 410-130-0255, 410-130-0365 and 410-130-0595

REPEAL: 410-137-0080, Ambulatory Surgical Services program

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Statutory Authority: ORS 409.050 and 414.065

Other Authority: 42 USC 1396a(bb), Title 42 Public Health of the Code of Federal Regulations

Statutes Implemented: ORS 414.065

Rule Summary: The Medical-Surgical Services program administrative rules govern Division of Medical Assistance Programs' (DMAP) payment for services to certain clients. DMAP amended OARs as follows:
410-130-0163: to remove language for Standard Benefits that is already addressed in DMAP General Rules (chapter 410, division 120);
410-130-0180: to remove codes that don't require submission of documentation and update the "not covered" services and supplies;
410-130-0200: to clarify that the treating practitioner is responsible to obtain prior authorization & update codes for bariatric surgeries, hysterectomies, hip resurfacing and dentistry performed in hospital or ASC settings;
410-130-0220: to update "excluded" codes;
410-130-0240: to add that practitioners can apply topical fluoride to children under age 7;
410-130-0255: to update immunization codes covered under VFC;
410-130-0365: to address prior authorization requirements and Medicare designated payment allowed for ancilary services and to distinguish coding between ASCs and Birthing Centers; and
410-130-0595: to appropriately describe MCM services and update mandatory topics.

All rules listed above were revised to improve readability and to take care of "housekeeping" corrections.

DMAP **repealed 410-137-0080**, thus making the Ambulatory Surgical Services program obsolete. Text from this rule is found in 410-130-0595.

6-4-09

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

410-130-0163
Standard Benefit Package
(1) The Division of Medical Assistance Programs (DMAP) does not cover some services under the Standard Benefit Package. Refer to General Rule 410-120-1210 for restrictions in other programs.
(2) DMAP covers medical supplies and equipment only when applied by the practitioner in the office setting for treatment of the acute medical condition. Durable medical equipment (DME) and medical supplies dispensed by DME providers are limited. Refer to DME Rules 410-122-0055 for specific information on coverage.
Stat. Auth.: ORS 409.050 and 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 for contraceptives such as birth control pills, spermicides and patches:
(a) Use an appropriate Current Procedural Terminology (CPT) therapeutic injection code for administration of injectables;
(b) Use an appropriate Healthcare Common Procedure Coding System (HCPCS) code for the specific drug. Do not bill for drugs under code 99070;
(c) When there is no specific HCPCS code for a drug or biological, use an appropriate unlisted code from the list below and bill at acquisition cost (purchase price plus postage):
(A) J3490;
(B) J3590;
(C) J7599;
(D) J7699;
(E) J7799;
(F) J8499;
(G) J8999;
(H) J9999;
(I) Include the name of the drug, National Drug Code (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 on all claim forms.
(3) For codes requiring prior authorization and codes that are Not Covered/Bundled, refer to OAR 410-130-0200 Table 130-0200-1 and OAR 410-130-0220 Table 130-0220-1.
(4) Not covered services and supplies include:
(a) Laetrile;
(b) Home pregnancy kits and products designed to promote fertility;
(c) Dimethyl sulfoxide (DMSO), except for instillation into the urinary bladder for symptomatic relief of interstitial cystitis;
(d) Infertility drugs;
(e) Sodium hyaluronate and Synvisc.
(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.

(A) DMAP cannot reimburse providers for a drug unless the drug manufacturer has signed an agreement with the Centers for Medicare and Medicaid Services (CMS) to participate in the Medicaid Drug Rebate Program.
(B) To verify that a drug manufacturer participates in the Medicaid Drug Rebate Program, visit the CMS website below to verify that the first five digits of the NDC number (labeler code) are listed as a participating drug company:
http://www.cms.hhs.gov/MedicaidDrugRebateProgram/10_DrugComContactInfo.asp
(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 client per week;
(C) Limited to five units per client per 30 days;
(D) Use code 90862 with modifier TC to bill for clozapine supervision.
Stat. Auth.: ORS 409.050 and 414.065
Stats. Implemented: ORS 414.065

410-130-0200
Prior Authorization
(1) For fee-for-service clients prior authorization (PA) is required for all procedure codes listed in Table 130-0200-1 regardless of the setting they are performed in. Refer to the Medical-Surgical Services Supplemental for details on where to obtain PA.
(2) For clients enrolled in a prepaid health plan (PHP), providers must obtain PA from the client's PHP.
(3) PA is not required:
(a) For clients with both Medicare and Medical Assistance Program coverage and the service is covered by Medicare. However, PA is still required for most transplants, even if they are covered by Medicare;
(b) For kidney and cornea transplants unless they are performed out-of-state;
(c) For emergent or urgent procedures or services;
(d) For hospital admissions unless the procedure requires PA.
(4) A second opinion may be requested by the Division of Medical Assistance Programs (DMAP) or the contractor before PA is given for a surgery.
(5) Treating and performing practitioners are responsible for obtaining PA.
(6) Refer to Table 130-0200-1 for all services/procedures requiring PA.
Table 130-0200-1
Stat. Auth.: ORS 409.010 and 414.065
Stats. Implemented: ORS 414.065

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 409.050 and 414.065
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 (an 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. Bill laboratory and radiology services with specific Current Procedural Terminology (CPT) codes.
(4) Maternity care and delivery:
(a) Use Evaluation and Management (E/M) 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. Healthcare Common Procedure Coding System (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 obstetrical care 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 the Division of Medical Assistance Programs (DMAP) 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 polysomnograms and multiple sleep latency tests (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 the DMAP 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.
(11) Medical practitioners may apply topical fluoride varnish during a medical visit to children under the age of 7 years who have limited access to a dental practitioner. Refer to Dental Services rule (Chapter 410 Division 123 Rule 1260).
Statutory Authority: ORS Chapter 409.050 and 414.065
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 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 409.050 and 414.065
Stats. Implemented: ORS 414.065

410-130-0365
Ambulatory Surgical Center and Birthing Center Services
(1) Ambulatory Surgical Centers (ASC) and Birthing Centers (BC) must be licensed by the Oregon Health Division. ASC and BC services are items and services furnished by an ASC or BC in connection with a covered surgical procedure as specified in the Medical-Surgical Services rule or in the Dental Services rule. Reimbursement is made at all-inclusive global rates based on the surgical procedure codes billed.
(2) If the client has Medicare in addition to Medicaid and Medicare covers a surgery, but not in an ASC setting, then the surgery may not be performed in an ASC.
(3) Global rates include:
(a) Nursing services, services of technical personnel, and other related services;
(b) Any support services provided by personnel employed by the ASC or BC facility;
(c) The client's use of the ASC's or BC's facilities including the operating room and recovery room;
(d) Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment related to the provision of the surgical procedure(s);
(e) Diagnostic or therapeutic items and services related to the surgical procedure;
(f) Administrative, record-keeping, and housekeeping items and services;
(g) Blood, blood plasma, platelets;
(h) Materials for anesthesia;
(i) Items not separately identified in section (4) of this rule.
(4) Items and services not included in ASC or BC Global Rate:
(a) Practitioner services such as those performed by physicians, licensed physician assistants, nurse practitioners, certified registered nurse anesthetists, dentists, podiatrists and Licensed Direct Entry Midwives (for birthing centers only);
(b) The sale, lease, or rental of durable medical equipment to ASC or BC clients for use in their homes;
(c) Prosthetic and orthotic devices;
(d) Ambulance services;
(e) Leg, arm, back and neck brace, or other orthopedic appliances;
(f) Artificial legs, arms, and eyes;
(g) Services furnished by a certified independent laboratory.
(5) ASCs and BCs will not be reimbursed for services that are normally provided in an office setting unless the practitioner has justified the medical appropriateness of using an ASC or BC through documentation submitted with the claim. Practitioner's justification is subject to review by the Division of Medical Assistance Programs (DMAP). If payment has been made and the practitioner fails to justify the medical appropriateness for using an ASC or BC facility, the amount paid is subject to recovery by DMAP.
(6) Procedure coding for non-Birthing Centers:
(a) Bill the same procedure codes billed by the surgeon;
(b) For reduced or discontinued procedures, use Common Procedural Terminology (CPT) instructions and add appropriate modifiers;

(c) Attach a report to the claim when billing an unlisted code;
(d) For billing instructions regarding multiple procedures, see rule 410-130-0380.
(7) Procedure coding for Birthing Centers:
(a) Bill code 59409 only once for a single vaginal delivery regardless of the total days that the client was in the facility for labor management, delivery and immediate postpartum care;
(b) For delivery of twins:
(A) Bill the delivery of the first twin with 59409; and
(B) Bill the delivery of the second twin with code 59409 on a separate line;
(c) When labor was managed in the BC but a delivery did not result, bill S4005 (Interim labor facility global) and attach a report documenting the circumstances.
(8) Prior authorization is required for all services listed in Table 130-0200-1. Refer to Rule 410-130-0200.
Stat. Auth.: ORS 409.050 and 414.065
Stats. Implemented: ORS 414.065

410-130-0595
Maternity Case Management (MCM)
(1) The primary purpose of the Maternity Case Management (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 billing of 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) Only one provider may provide MCM services to the client at a time. The provider must coordinate care to ensure that duplicate claims for MCM services are not submitted to the Division of Medical Assistance Programs (DMAP).
(5) Definitions:
(a) Case Management -- An ongoing process to assist and support an individual pregnant client in accessing necessary health, social, economic, nutritional, and other services to meet the goals defined in the Client Service Plan (CSP)(defined below);
(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, address the CSP and provide an on-going relationship development between the client and the visiting provider. The visit occurs in the client's home unless documentation of extenuating circumstances indicates that the encounter must be conducted elsewhere;
(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 (defined below) and includes a client discharge plan/summary;
(d) High Risk Case Management -- Intensive level of 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 -- A client who has a current (within the last year) documented alcohol, tobacco or other drug (ATOD) abuse history, or who is 17 or under, or has 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 the 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)(a)(A-I);
(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) The Maternity Case Manager must be a Division of Medical Assistance Programs (DMAP) enrolled provider or deliver services under an appropriate DMAP enrolled provider. See DMAP General Rules 410-120-1260 for provider enrollment qualifications;
(c) All of the above must have a minimum of two years of related and relevant work experience;
(d) 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;
(e) The Maternity Case Manager must sign off on all services delivered by a paraprofessional;
(f) 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 be:
(a) A licensed dietician (LD) licensed by the Oregon Board of Examiners of Licensed Dieticians; and
(b) A registered dietician (RD) credentialed by the Commission on Dietetic Registration of the American Dietetic Association (ADA).
(8) Documentation Requirements:
(a) Documentation is required for all MCM services in accordance with DMAP General Rules 410-120-1360; and
(b) A correctly completed DMAP form 2470, 2471, 2472 and 2473 or their equivalents meet minimum documentation requirements for MCM services.
(9) G9001 -- Initial Assessment must be performed by a licensed Maternity Case Manager as defined under (6)(a)(A-G) above:
(a) Services include:
(A) Client assessment as outlined in the "Definitions" section of this rule;
(B) Development of a CSP which addresses identified needs;
(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 the CSP to the prenatal care provider;
(E) Communicating pertinent information to the prenatal care provider and 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) The Initial Assessment (G9001) is billable once per pregnancy per provider and must be performed before providing any other MCM services. Only a Home/Environmental Assessment (G9006) and a Case Management Visit (G9012) may be performed and billed on 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 includes 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) Care coordination as follows:
(A) Contact with Department of Human Services (DHS) case worker, if assigned;
(B) Maintain contact with prenatal care provider to ensure service delivery, share information, and assist with coordination;
(C) Contact with other community resources/agencies to address needs;
(d) Linkage to client services indicated in the CSP:
(A) Make linkages, provide information and assist the client in self-referral;
(B) Provide linkage to labor and delivery services;
(C) Provide linkage to family planning services as needed; (e) Ongoing nutritional evaluation with basic counseling and referrals to nutritional counseling, as indicated;
(f) 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, 2008). Routinely:
(A) Ask all 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;
(g) Provide training and education on all mandatory topics - Refer to Table 130-0595-2;
(h) Client advocacy as necessary to facilitate access to benefits or services;
(i) Assist client in achieving the goals in the CSP;
(j) G9002 is 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;
(k) G9002 is billable once per pregnancy.
(11) G9009 -- Case Management (Partial Service):
(a) Can be billed when the CSP has been developed and MCM services were initiated during the prenatal period and partially completed;
(b) Provided MCM 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 High Risk Case Management services for the client for more than three months after the client was identified as high risk; AND
(c) Provided at least eight Case Management Visits;
(d) G9005 is billable after the delivery and only once per pregnancy;
(e) G9005 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 high risk case management services for the client for three months or less after the client has been identified as high risk; OR
(c) Provided less than eight Case Management Visits;
(d) G9010 is billable after the delivery and once per pregnancy;
(e) G9010 can be billed in addition to G9002 or G9009.
(14) S9470 -- Nutritional Counseling:
(a) Is 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 Women, Infants and Children (WIC) guidelines;
(E) Eating disorder;
(F) Gestational diabetes;
(G) Hyperemesis;
(H) Pregnancy induced hypertension (pre-eclampsia); or
(I) Other identified conditions;
(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) S9470 is billable only once per pregnancy.
(15) G9006 -- Home/Environmental 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) G9006 may be billed only once per pregnancy, except an additional Home/Environmental Assessments may be billed with documentation of problems which necessitate follow-up assessments 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) G9011 is billable 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:
(A) An evaluation and/or revision of objectives and activities addressed in the CSP: and
(B) At least two training and education topics listed in Table 130-0595-2;
(b) Four Case Management Visits (G9012) may be billed per pregnancy. Telephone Case Management Visits (G9011) are included in this limitation;
(c) Six additional Case Management Visits may be billed if the client is identified as high risk;
(A) These additional visits may not be billed until after delivery;
(B) These additional six visits may only be submitted with or after High Risk Full (G9005) or High Risk Partial (G9010) Case Management has been billed. Telephone Case Management Visits (G9011) are included in this limitation;
(d) Maternity Case Management Visits (G9012) may be provided in the client's home or other site due to documented extenuating circumstances.
Table 130-0595-1
Table 130-0595-2

Stat. Auth.: ORS 409.050 and 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	21275	33933 (*2)
00796	21280	33935 (*2)
00938	22554	33944-33945 (*2)
11960	22556	33976
11970	22558	33979
15822	22585	38204-38215 (*2)
15823	22590	38230 (*2)
17106-17108 (*1)	22595	38240 (*2)
20910	22600	38241 (*2)
21050	22610	40840
21120	22612	40842-40845
21121	22614	43631-43634
21137-21139	22630	44135 (*2)
21141-21143	22632	43644-43645 (*5)
21145-21147	22800	43770-43771 (*5)
21150	22802	43773 (*5)
21151	22804	43846-43848 (*5)
21154	22808	44715-44721 (*2)
21155	22810	47135 (*2)
21159	22812	47136 (*2)47140-
21160	22841-22848	47147 (*2)
21172	22851	48160 (*2)
21175	23472	48551-48552 (*2)
21179-21184	26560-26562	48554 (*2)
21188	27447	48556 (*2)
21193-21196	28340	49000 (*3)
21198	28341	49320
21199	28344	49329
21206	28345	51840
21208	30400	51841
21209	30410	51845
21256	30420	54360
21260	30430	54400
21261	30435	54401
21263	30450	54405
21267	30460	54408
21268	30462	54410
21270	32851-32856 (*2)	54411

(*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
(*5) Primary Care Provider (PCP) must refer for evaluation pursuant to Prioritized List guidelines directed to DMAP Policy for review and transmittal to the Medical-Surgical PA contractor.

Table 130-0220-1 Not Covered/Bundled Services

Refer to the current Prioritized List of Health Services for additional services that are not covered.

Refer to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Rules (Division 410 Chapter 122) for not covered Healthcare Common Procedure Coding System (HCPCS) codes not addressed below.

BND = bundled services that are included in the base service

00802	29867	43257
19316	29868	43647
20696	31620	43648
20697	32491	43659
21685	32850 BND	43842
22523	32998	43843
22524	33140	43881
22525	33141	43882
22526	33548	43886
22527	33930 BND	43887
22856	33940 BND	43888
22857	33968	44132 BND
22861	36455	44133
22862	37210	44136
22864	38129	44979
22865	38589	45391
27080	41512	45392
28890	41530	45512
29866	41821	46505

97028
97033
97034
97039
97139
97537
97802-97804
99000-99002 BND
99024
99026
99027
99056
99070 (*1)
99071 BND
99075
99100 BND
99116 BND
99135 BND
99140 BND
99174
99360 (*3)
A4570 (*4)
A4580 (*4)
A4590 (*4)
A4641
A9579 BND
G0166
G0168
G0219
G0252
M0076
M0100
M0300-M0301
P2028-P2029
P2031
P2033
P2038
P7001
P9010-P9060
Q0035
Q0091 BND
Q0092 BND
Q0115

(*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

Table 130-0255-1 Vaccines for Children

90632 (*1)	90660	90714
90633	90669	90715
90636 (*1)	90680	90716
90647	90681	90721 (*2)
90648	90696	90723
90649	90698	90732
90655	90700	90733
90656	90702	90734
90657	9070790710	90744
90658	90713	90748

(*1) Age 18 only.

(*2) Bill when 90700 and 90648 are given combined in one injection.

Table 130-0595-1 Environmental Assessment

Housing Characteristics
Location of home and proximity to exposures
General assessment and condition of home as shelter
Number of bedrooms and number of persons
Heating and cooling
Ventilation and windows
Locking entrance
Phone service
Running/potable water
Access to bathroom
Sanitation/sewage and garbage

General Safety
Guns/weapons: locked and unloaded
Lighting adequate for safety
Fall/Trip hazards
Temperatures of hot tubs and hot water tanks
Non-slip shower and bath surfaces

Food Safety
Food preparation facilities
Refrigeration
Cleanable surfaces
Food storage facilities
Health adequacy: safety and sanitation

Toxins/Teratogens
Pesticides
Lead exposure: peeling paint, lead pipes and lead dust
Household cleaners

Indoor Air
Tobacco smoke – second- and third-hand
Wood/Pellet stoves
Mold and mildew
Carbon monoxide risk
Chemical use: in or near home
Radon risk

Table 130-0595-2 MCM Training and Education Topics

MANDATORY TOPICS

Alcohol, tobacco and other drug exposure
Maternal oral health
Breastfeeding promotion
Perinatal mood disorders
Prematurity and pre-term birth risks
Maternal/Fetal HIV (Human Immunodeficiency Virus) and Hepatitis B transmission
Nutrition, healthy weight and physical activity
Intimate Partner Violence (IPV)

NON-MANDATORY TOPICS

Pregnancy and Childbirth

Common discomforts and interventions
Labor and birth process
Coping strategies
Relationship changes
Stress reduction
Pregnancy danger signs and symptoms
Fetal growth and development
Safety in automobiles: proper use of seat belts and infant car seats
Other emergencies

Health Status

Medications
Digestive tract changes
Food availability
Food selection and preparation
Mercury consumption from eating fish
Other existing health conditions during pregnancy

Environmental Health

Housing
Safety and sanitation
Toxins/Teratogens
Occupational exposures
Drinking water

Non-fluoridated water community
Home cleaning supplies
Tobacco smoke exposure
Asthma triggers
Lead exposure and screening

Parenting
Infant care
Early childhood caries prevention
Nutrition, feeding and infant growth
Infant sleep patterns and location
SIDS (Sudden Infant Death Syndrome) and "Back to Sleep"
Infant developmental milestones
Immunizations and well child care
Infant/Parent interaction
Bonding and attachment
Infant communication patterns and cues
Parental frustration and sleep deprivation
Child nurturing, protection and safety

Other Topics
Individual and family emergency preparedness
Family planning
Sexually transmitted diseases
Inter-conception and pre-conception health
Community resources
Obtaining accurate health information