



# Oregon

Theodore R. Kulongoski, Governor

## Department of Human Services

Health Services

Office of Medical Assistance Programs

500 Summer Street NE, E35

Salem, OR 97301-1077

Voice (503) 945-5772

FAX (503) 373-7689

TTY (503) 378-6791



To: OMAP American Indian/Alaska Native (AI/AN)  
Service Providers

From: Joan Kapowich, Manager  
OMAP Program and Policy

Re: AI/AN Administrative Rules, RB Revision 1

Effective: **October 1, 2003**

**OAR 410-146-0022** is adopted to reflect passage of SB 878 from the 2003 Legislative session regarding Standard benefits.

**OAR 410-146-0260 and -0320** have been repealed.

**OAR 410-146-0040, -0060, -0075, -0080, -0120, -0130** have been amended as follows:

Rules listed above will be amended to add new tables, billing code and modifier requirements; and, education/training topics to Maternity Case Management for Oral Health education and Fetal Alcohol. OHP Standard Dental Benefit rules will be repealed. Some rules will be combined to clarify language and others amended to take care of necessary housekeeping corrections.

If you have billing questions, contact a Provider Services Representative toll-free at 1-800-336-6016 or direct at 503-378-3697. Please replace these rules in your hard copy of the rulebook. A complete set of the rules and the new supplemental information for each program is available by calling 1-800-527-5772 or by downloading them from OMAP's web site.

***“Assisting People to Become Independent, Healthy and Safe”***  
**An Equal Opportunity Employer**

**DEPARTMENT OF HUMAN SERVICES, DEPARTMENTAL  
ADMINISTRATION AND MEDICAL ASSISTANCE PROGRAMS**

**DIVISION 146**

**AMERICAN INDIAN/ALASKA NATIVE**

410-146-0000 Foreword

410-146-0020 Memorandum of Agreement (MOA)

410-146-0021 AI/AN Provider Enrollment

410-146-0022 OHP Standard Benefit for AI/AN Clients

410-146-0025 Reimbursement for AI/AN Health Care Facilities

410-146-0040 ICD-9-CM Diagnosis Codes

410-146-0060 Prior Authorization

410-146-0075 Copayment for Standard Benefit Package

410-146-0080 Professional Services

410-146-0100 Vaccines for Children (VFC)

410-146-0120 Maternity Case Management Services

410-146-0130 Modifiers

410-146-0140 Tobacco Cessation

410-146-0160 Administrative Medical Examinations and Reports

410-146-0180 Durable Medical Equipment and Medical Supplies

410-146-0200 Pharmacy

410-146-0220 Death With Dignity

410-146-0240 Transportation

410-146-0340 Medicare/Medical Assistance Program Claims

## **410-146-0000 Foreword**

(1) The Office of Medical Assistance Programs (OMAP) American Indian/Alaska Native (AI/AN) billing guide is designed to assist AI/AN Tribal Clinics/Health Centers, Indian Health Services (IHS), Federally Qualified Health Clinics (FQHC) with a 638 designation that are enrolled as AI/AN providers to deliver health care services and prepare health claims for clients with Medical Assistance Program coverage. Providers should follow the OMAP rules in effect on the date of service.

(2) AI/AN clients can choose to be exempt from managed care organizations (see OAR 410-141-0060) and receive their care from AI/AN Health Care Facilities or any other private provider enrolled with OMAP.

(3) AI/AN clients can choose to enroll in a managed care organization and continue to receive care on an infrequent basis from AI/AN Health Care Facilities. If the client chooses to remain in a managed care organization they must follow all managed care rules when seeking services outside of AI/AN Health Care Facilities. When a client chooses to utilize services through a managed care organization they must contact their plan for coverage and prior authorization information.

(4) This guide contains information on policy, special programs services outside of the encounter rate such as pharmacy, lab, x-ray, and Durable Medical Equipment (DME), etc., and criteria for some services. All OMAP guides are intended to be used in conjunction with the OMAP General Rules and the Oregon Health Plan Administrative Rules.

(5) AI/AN Health Care Facilities that have a pharmacy will need OMAP's Pharmacy guide. AI/AN pharmacies that provide DME and Medical Supplies will also need the DMEPOS guide.

(6) The Health Services Commission's Prioritized List of Health Services (see OAR 410-141-0520), defines the covered services under OMAP.

(7) Note: FQHCs with a 638 designation must be enrolled as an AI/AN provider to bill using these rules and to receive the Memorandum of Agreement (MOA) reimbursement rate. If an FQHC with a 638 designation chooses to remain enrolled as an FQHC, it must follow all the rules contained within the FQHC and Rural Health Clinic (RHC) administrative rules and guidelines. FQHCs with a 638 designation are recognized under CMS's MOA. Urban Tribal Clinics are enrolled as an FQHC and must follow all the rules contained within the FQHC and RHC administrative rules and guidelines. Urban Tribal Clinics are not recognized under CMS's MOA.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02

## **410-146-0020 Memorandum of Agreement (MOA)**

(1) This outlines the State of Oregon, Office of Medical Assistance Programs' (OMAP) interpretation of CMS's Memorandum of Agreement (MOA) and serves as guidance for submitting claims with the Indian Health Services (IHS) encounter rate.

(2) An encounter is defined as "A face-to-face contact between a health care professional and an IHS beneficiary eligible for the Medical Assistance Program for the provision of Title XIX/CHIP defined services in an IHS, American Indian/Alaska Native (AI/AN) Tribal Clinic or Health Center, or a Federally Qualified Health Clinic (FQHC) with a 638 designation within a 24-hour period ending at midnight, as documented in the client's medical record." IHS, AI/AN Tribal Clinic or Health Center, or an FQHC will be referred to as an AI/AN Health Care Facility.

(3) OMAP recognizes that an encounter can occur either within or through the AI/AN Health Care Facility.

(4) OMAP considers the following encounters to be reimbursable under the MOA encounter rate for health services provided within the practitioner's scope of services by: Physicians, Licensed Physician Assistants, Nurse Practitioners, Nurse Midwives, Dentists, Pharm D, other specialized nurse practitioners, nurses under the supervision of an MD, or other health care professionals including but not limited to mental health and alcohol and drug counselors or other para-professionals, including Community Health Representatives under the supervision of one of the above practitioners to provide: Medical, Diagnostic, Screening, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Drug, Maternity Case Management, Speech, Hearing, or, Home Health Services.

(5) OMAP considers lab, x-ray, drugs/biologicals (prescriptions) and medical transportation services to be outside the encounter rate and are reimbursed under the OMAP fee-for-service system.

(6) OMAP acknowledges that multiple encounters can occur on the same date of service. The following are examples of types of encounters that could be considered separate encounters:

(a) Dental;

(b) Mental Health;

(c) Alcohol and Drug;

(d) Vision;

(e) Medical: More than one outpatient visit with a medical professional within a 24-hour period for a single diagnosis constitutes a single encounter. More than one outpatient visit with a medical professional within a 24-hour period for a different principal diagnosis constitutes more than one encounter;

(f) Physical or Occupational Therapy.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02

## **410-146-0021 AI/AN Provider Enrollment**

(1) Any Indian Health Services (IHS) Health facility, federally recognized Indian tribe, tribal organization or Federally Qualified Health Clinic (FQHC) with a 638 designation, excluding Urban Tribal Clinics, that provides health care services as defined in rule may enroll as an American Indian/Alaska Native (AI/AN) Clinic provider.

(2) Urban Tribal Clinics that are an FQHC with 638 designation cannot enroll as an AI/AN Clinic provider. The Centers for Medicare and Medicaid Services (CMS) does not recognize Urban Tribal Clinics under the Memorandum of Agreement (MOA). Urban Tribal Clinics with a 638 designation must enroll as an FQHC provider and follow all the rules contained within the FQHC and Rural Health Clinic (RHC) guide.

(3) Qualifying FQHCs with a 638 designation can choose to enroll as an AI/AN provider or an FQHC provider.

(4) To qualify under the MOA a qualifying FQHC with 638 status must be enrolled as an AI/AN provider and follow the rules contained in the AI/AN billing guide.

(5) If a qualifying FQHC with a 638 designation chooses to remain enrolled as an FQHC that clinic must follow all the rules contained within the FQHC and RHC guide.

(6) A qualifying FQHC with a 638 designation cannot enroll under both programs even if the clinic accepts clients that are non-native.

(7) If a qualifying FQHC with a 638 designation applies to enroll as an AI/AN provider that clinic must submit the following documentation:

(a) Copy of the grant; and

(b) Copy of the grant award.

(8) If an IHS or other federally recognized Indian tribe or tribal organization applies to enroll as an AI/AN provider that clinic must show proof of federal recognition.

(9) If an IHS or other federally recognized Indian tribe or tribal organization has a pharmacy or supplies Durable Medical Equipment (DME) and Medical Supplies that clinic must apply for a pharmacy provider number and/or apply for a DME provider number in addition to the clinic provider number.

(10) If an IHS or other federally recognized Indian tribe or tribal organization provides van/sedan transportation the clinic does not apply for a transportation provider number. Their AI/AN clinic number is used as outlined in OAR 410-146-0240.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 59-2002, f. & cert. ef. 10-1-02

## **410-146-0022**

(1) OHP Standard Benefit for AI/AN Clients

(2) Once OMAP receives authorization to implement SB 878 from the Centers for Medicare and Medicaid Services, OHP Standard AI/AN clients have the following benefits:

(a) AI/AN Clients eligible for the OHP Standard Benefit are allowed by the authority of SB 878 to receive all services allowed under the OHP Plus Benefit that are reimbursed by CMS at 100% FPL;

(b) AI/AN Clients eligible for the OHP Standard Benefit do not change eligibility group unless allowed by OAR. For example OHP Standard female client becomes pregnant and moves into OHP Plus during pregnancy;

(c) Excluded Services: Transportation.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

October 1, 2003

## **410-146-0025 Reimbursement for AI/AN Health Care Facilities**

(1) Services provided by facilities of the Indian Health Service (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organizations, and funded by Title I or III of the Indian Self Determination and Education Assistance Act (Public Law 93-638), are paid at the rates negotiated between the Centers for Medicare and Medicaid Services (CMS) (formerly Health Care Financing Administration (HCFA)) and IHS which are published in the Federal Register or Federal Register Notices.

(2) The outpatient per visit rate is also known as the IHS encounter rate and is defined in rules 410-146-0020 and 410-146-0080.

(3) Providers that are eligible for reimbursement under the IHS encounter rate are defined in rules 410-146-0020, 410-146-0080 and 410-146-0120.

(4) If the negotiated rates for the IHS encounter is published in the Federal Register after the effective date of the new rate the Office of Medical Assistance Programs (OMAP) will retroactively reimburse the difference for all claims paid to American Indian/Alaska Native (AI/AN) Health Care Facilities with dates of service on or after the effective date of the new rate.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 36-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02

## **410-146-0040 ICD-9-CM Diagnosis Codes**

(1) The appropriate code or codes from 001.0 through V82.9 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reasons for the encounter/visit. Diagnosis codes are required on all claims, including those submitted by independent laboratories and portable radiology including nuclear medicine and diagnostic ultrasound providers. Always provide the client's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(2) The principal diagnosis is listed in the first position; the principal diagnosis is the code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Up to three additional diagnosis codes may be listed on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect client care, treatment, or management.

(3) The diagnosis codes must be listed using the highest degree of specificity available in the ICD-9-CM. A three-digit code is used only if it is not further subdivided. Whenever fourth-digit subcategories and/or fifth-digit subcategories are provided, they must be assigned. A code is invalid if it has not been coded to its highest specificity.

(4) The Office of Medical Assistance Programs (OMAP) requires accurate coding and applies the national standards in effect for calendar years 2003 and 2004 set by the American Hospital Association, American Medical Association, and Centers for Medicare and Medicaid Services (CMS). OMAP has unique coding and claim submission requirements for Administrative Exams; specific diagnosis coding instructions are provided in the Administrative Examination and Report Billing provider rules.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

October 1, 2003

## **410-146-0060 Prior Authorization**

(1) No prior authorization (PA) is required for services provided within an American Indian/Alaska Native (AI/AN) Health Care Facility with the sole exception of pharmacy, DME and Hospital Dentistry services. Refer to the Pharmacy and DME program rules for more detailed information.

(2) If a client is enrolled in a managed care plan there may be PA requirements for some services that are provided through the managed care plan. Contact the client's managed care plan for specifics.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

October 1, 2003

## **410-146-0075 Client Copayments**

(1) American Indian/Alaska Native (AI/AN) are not required to pay copayments for services provided through Indian Health Services (IHS), a Federally recognized Indian Tribe or Tribal Organization. This includes any health care services provided to the AI/AN member and is defined as provided directly, by referral, or under contracts or other arrangements between IHS, a Federally recognized Indian Tribe, Tribal Organization or an Urban Tribal Health Clinic and another health care provider.

(2) AI/AN are not required to pay copayments for services provided at an Urban Tribal Health Clinic.

(3) AI/AN Tribal Health Facilities may not charge copayments to non-AI/AN Medical Assistance Program clients receiving care at the Tribal Health Facility.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

October 1, 2003

## **410-146-0080 Professional Services**

(1) Medical, Diagnostic, Screening, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Drug, Maternity Case Management, Speech, Hearing, or, Home Health services are not limited except as directed by the General Rules - Medical Assistance Benefits: Excluded Services and Limitations and the Health Services Commission's (HSC) Prioritized List of Health Services (List) as follows:

(a) Coverage for diagnostic services and treatment for those services funded on the HSC List, and;

(b) Coverage for diagnostic services only, for those conditions that fall below the funded portion of the HSC List;

(c) The date of service determines the appropriate version of the General Rules and the HSC List to determine coverage;

(d) The OHP Standard Benefit Package is a limited benefit package. See OAR 410-120-1235 for details.

(2) American Indian/Alaska Native (AI/AN) Health Care Facilities are eligible under the Memorandum of Agreement (MOA) for reimbursement of professional services. These services are billed on CMS-1500 using diagnoses that meet national coding standards, or as specifically directed in rule.

(3) Encounter:

(a) An encounter is defined as "A face-to-face contact between a health care professional and an Indian Health Services (IHS) beneficiary eligible for the Medical Assistance Program for the provision of Title XIX/CHIP defined services in an AI/AN Health Care Facility within a 24-hour period ending at midnight, as documented in the client's medical record";

(b) An encounter can occur either within or through the AI/AN Health Care Facility;

(c) The following encounters are reimbursable under the MOA encounter rate: Physicians, Licensed Physician Assistants, Nurse Practitioners, Nurse Midwives, Dentists, Pharm D, or other health care professionals to provide: Medical, Diagnostic, Screening, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Drug, Maternity Case Management, Speech, Hearing, or Home Health Services;

(d) Professional services provided in a hospital setting;

(e) Services outside of the encounter rate include but not limited to Pharmacy, DME, Lab, Radiology, Targeted Case Management, Administrative Examinations, and Medical Transportation. These services are reimbursed under the OMAP fee-for service system;

(f) Effective March 1, 2003, the OHP Standard Benefit has limited services. See OAR 410-120-1235 for detailed list of non-covered services.

(4) Multiple Encounters:

(a) Multiple encounters may occur on the same date of service. Any of these encounters could occur and be reported separately:

(A) For Dental refer to Table 146-0080-2;

(B) Mental Health;

(C) Alcohol and Drug;

(D) Vision;

(E) Medical: More than one outpatient visit with a medical professional within a 24-hour period for the same diagnosis constitutes a single encounter. More than one outpatient visit with a medical professional within a 24-hour period for different diagnoses is reported as two or more encounters;

(F) Physical or Occupational Therapy.

(b) If a client has multiple encounters on the same date of service, list the appropriate codes on separate lines. For example, if a client comes into the clinic for a tetanus shot and has a vision exam on the same day, the office visit code is listed on line 1 in Field 24 and the vision exam code is listed on line 2 in Field 24;

(c) If a client has multiple medical professional encounters on the same date of service, then list the most appropriate Evaluation and Management code on line 1 in Field 24 and indicate the total number of encounters in Field 24G (Days or Units);

(d) In Field 21 of the CMS-1500, 1-4 (Diagnosis or Nature of Illness or Injury), code the medical diagnosis according to national coding guidelines to the highest degree of specificity available;

(e) When there are multiple encounters and one of the services is a medical service, always code that service first and then list any other diagnoses as space permits (there is a maximum of four diagnoses available on the CMS-1500). If the medical condition requires the use of all four-diagnosis fields then do not code the other services. If there is not a medical service, for example the client had two encounters, dental and vision, no specific order for the diagnosis codes is required.

(5) Codes for AI/AN and Non-Native OMAP Client Encounters -- Due to the unique billing and payment methodology and the implementation of the Health Insurance Portability Accountability Act (HIPAA), OMAP has converted from using a single OMAP unique procedure code to report an encounter with selected CPT/HCPCS codes. The billing guidelines provided in the AI/AN billing rules limits AI/AN Health Care Facilities to specific CPT/HCPCS codes when reporting an encounter that may not be consistent with national coding standards. This does not apply to ICD-9-CM diagnosis coding. Bill OMAP with the procedure codes indicated in each service category for services included in the AI/AN encounter rate. For services that are not included in the encounter rate or under the MOA

please refer to the Services Not Eligible Under the MOA section of the AI/AN billing rules for billing instructions:

(6) When billing for a clinic visit, select the most appropriate CPT/HCPCS procedure code ranges shown in Table 146-0080-1.

(7) It is the HSC's intent to cover reasonable diagnostic services to determine diagnoses on the HSC List, regardless of their placement on the HSC List.

Table 146-0080-1

Table 146-0080-2

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

October 1, 2003

## Table 146-0080-1 AI/AN Encounters Codes & Modifiers

Effective October 1, 2003

<b>Service</b>	<b>Procedure Codes</b>	<b>Modifier</b>
Alcohol and Drug Services	Use HCPCS H0001-H0007	
Clozaril Management Services	Use CPT 90862	
Evaluation & Management (E&M): Primary Care Services	Use CPT 99201-99350, 99372 or 99381-99440	
E&M visit for Family Planning	Use appropriate CPT E&M outlined above	and FP
E&M visit includes Vaccine for Children service	Use appropriate CPT E&M outlined above	and SL
E&M visit immunization for high risk recommended populations	Use appropriate CPT E&M outlined above	and SK
If Administration of an immunization is the sole purpose of the clinic visit	Use CPT 90471	and SL or SK as appropriate
E&M for a significant, separately identifiable E&M on same date of service OAR 410-147-0140	Use appropriate CPT E&M outlined above	and 25
<sup>1</sup> Medicaid EPDST Services: Evaluation & Management	Use appropriate CPT 99201-99340, 99372 or 99381-99440	and EP
<sup>2</sup> Medical/Surgical Treatment for services not reported w/E&M code	Use HCPCS T1015	and SU
Delivery Services: to report delivery services. Excludes prenatal, antepartum or postpartum services.	Use CPT 59409, 59514, 59612 or 59620	
<sup>4</sup> Antepartum or Postpartum	Use CPT 99201-99340, 99372,	and TH

Visits, Prenatal care: Select the most appropriate CPT.	99381-99440 and <sup>4</sup> T1015	
For Maternity Case Management (MCM) Use for all MCM encounters	Use HCPCS G9012	
Ophthalmological Services. Excludes exams for the purpose of prescribing glasses or contacts	Use CPT 92002-92014	
Eye Exams for the purpose of prescribing glasses or contacts.	Use HCPCS S0620-S0621	
<sup>2</sup> Ophthalmological Treatment: Not otherwise defined above.	Use HCPCS T1015	and SU
Eye Glasses	Use CPT 92340-92353	
Fitting, Dispensing and Repair	Use CPT 92370-92371	
Physical Therapy and Occupational Therapy: for all physical medicine and rehabilitation services.	Use CPT 97001-97004	
Dental Exams	Use HCPCS D0120-D0180	
Dental Prophylaxis	Use CDT-4 D1110-D1203	
Fluoride varnish	CDT-4/HCPCS D1201 or D1203	
<sup>3</sup> Dental prevention direct services provided as the result of an State of Oregon sponsored grant project	Use CDT-4/HCPCS D0120-D0180, D1110-D1203	and Q2
<sup>2</sup> Dental Procedures: Not listed above.	Use HCPCS T1015	and SU
Outpatient Mental Health: Plus Benefit	Use CPT 90801-90862	
Outpatient Mental Health: Standard Benefit Assessment	Use CPT 90801, 90862, or 99241-99255	

Outpatient Mental Health: Standard Benefit Crisis Intervention	Use HCPCS S9485	
Outpatient Mental Health: Standard Benefit Medication Management	Use CPT 90862	
Outpatient Mental Health: Standard Benefit Consultation.	Use CPT 99241-99245	
Outpatient Mental Health: Standard Benefit ECT	Use CPT 90870-90871	
Tobacco Cessation: Must meet the criteria outlined for Tobacco Cessation;	Use HCPCS S9075 or G9016	

<sup>1</sup>There is specific requirements when providing Medicaid EPDST Services. For reference EPSDT Guidelines and Requirements have been provided below. These requirements are outlined in OAR 410-130-0245 and Tables 0245-1 through 245-5.

<sup>2</sup>For procedures or treatments that would be not have been reported using the CPT Evaluation and Management codes use T1015 with the modifier SU. T1015 is a nationally recognized HCPCS code that denotes a per diem encounter rate.

<sup>3</sup>Participants in State of Oregon grant activities for Oral Health Prevention are notified directly. If the AI/AN Tribal Health Facility or Indian Health Services has not received notification of participation DO NOT use the “Q2” modifier.

<sup>4</sup>For Clinics that have MCO contracts and provide OB care, paid at a single global rate may use T1015 code with the modifier TH and zero paid amount for clients enrolled in an MCO. Make agreements with the MCO regarding the use of this code combination. This would be used for all OB visits except the final encounter that is submitted as the global rate.

**Table 146-0080-2 Covered Dental Services Effective October 1, 2003**

The rates listed in this table are for AI/AN dental providers.

Codes listed in this table are covered services.

**Dental services for AI/AN Clinics are billed with ICD-9-CM diagnoses.**

D0120	D0274	D0480	D2150	D2722	D2957
D0140	D0277	D0502	D2160	D2751	D2970
D0150	D0290	D1110	D2161	D2752	D2980
D0160	D0310	D1120	D2330	D2910	D3220
D0170	D0320	D1201	D2331	D2920	D3221
D0180	D0321	D1203	D2332	D2930	D3230
D0210	D0322	D1320	D2335	D2931	D3240
D0220	D0330	D1351	D2390	D2932	D3310
D0230	D0340	D1510	D2391	D2933	D3320
D0240	D0350	D1515	D2392	D2940	D3330
D0250	D0415	D1520	D2393	D2950	D3331
D0260	D0472	D1525	D2394	D2951	D3332
D0270	D0473	D1550	D2710	D2954	D3333
D0272	D0474	D2140	D2721	D2955	D3351

D3352	D5213	D5731	D5924	D5960	D7285
D3353	D5214	D5740	D5925	D5983	D7286
D3950	D5410	D5741	D5926	D5984	D7287
D4210	D5411	D5750	D5928	D5985	D7320
D4240	D5421	D5751	D5929	D5986	D7340
D4241	D5422	D5760	D5931	D5987	D7350
D4245	D5510	D5761	D5932	D6930	D7440
D4260	D5520	D5820	D5933	D6972	D7441
D4261	D5610	D5821	D5934	D6980	D7450
D4268	D5620	D5850	D5935	D7111	D7451
D4341	D5630	D5851	D5936	D7140	D7471
D4342	D5640	D5911	D5937	D7210	D7490
D4355	D5650	D5912	D5951	D7220	D7510
D4910	D5660	D5913	D5952	D7230	D7520
D4920	D5710	D5915	D5953	D7240	D7530
D5110	D5711	D5916	D5954	D7241	D7540
D5120	D5720	D5919	D5955	D7250	D7550
D5130	D5721	D5922	D5958	D7260	D7560
D5140	D5730	D5923	D5959	D7270	D7610

D7620	D7950	D8660	D9630
D7630	D7970	D8670	D9930
D7640	D7980	D8680	D9999
D7650	D7981	D8690	
D7660	D7982	D8999	
D7670	D7983	D9110	
D7680	D7990	D9211	
D7710	D7997	D9212	
D7720	D8010	D9220	
D7730	D8020	D9221	
D7740	D8030	D9230	
D7750	D8040	D9241	
D7760	D8050	D9242	
D7770	D8060	D9248	
D7780	D8070	D9310	
D7910	D8080	D9420	
D7911	D8090	D9430	
D7912	D8210	D9440	
D7920	D8220	D9610	

## **410-146-0100 Vaccines for Children (VFC)**

(1) American Indian/Alaska Native (AI/AN) Health Care Facilities are eligible under the Memorandum of Agreement (MOA) for reimbursement for the administration of vaccines. These services are billed on a CMS-1500 using diagnoses that meet national coding standards, the appropriate encounter code, and type of service "1."

(2) The Vaccines for Children (VFC) Program was implemented by the Office of Medical Assistance Programs (OMAP) on April 1, 1996. Under this federal program certain immunizations are free for clients ages 0 through 18. For more information on how to enroll for the VFC Program, call the Oregon Health Division.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02

## **410-146-0120 Maternity Case Management Services**

(1) American Indian/Alaska Native Health Care Facilities are eligible for reimbursement for Maternity Case Management (MCM) services. These services are billed on a CMS-1500 using diagnoses that meet national coding standards, HCPCS code G9012, and type of service "1."

(2) The primary purpose of the MCM program is to optimize pregnancy outcomes including the reduction of low birth weight babies. MCM services are intended to target pregnant women early during the prenatal period and can only be initiated when the client is pregnant and no later than the day prior to delivery. MCM services cannot be initiated the day of delivery, during postpartum or for newborn evaluation. Clients are not eligible for MCM services if the MCM initial evaluation has not been completed prior to the day of delivery.

(3) 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 post-partum period;

(c) Is an additional set of services over and above medical management of pregnant clients;

(d) Allows for billing for intensive nutritional counseling services.

(4) 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.

(5) Note: In situations where multiple providers are seeing one client for MCM or other Targeted Case Management services, the case manager must coordinate care to ensure claims are not submitted to

the Office of Medical Assistance Programs (OMAP) if services are duplicated.

(6) Definitions:

(a) Case Management -- An ongoing process to assist the 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 client encounter that must include two or more specific training and education topics and provides ongoing relationship development between the client and the case manager. May be provided in the client's home or other site;

(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 instrument;

(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. Data sources 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.

(h) Nutritional Counseling -- Intensive nutritional counseling for clients who have at least one of the following documented conditions:

- (A) Chronic disease, e.g., diabetes, renal disease;
  - (B) Hematocrit (Hct) less than 34 (Hemoglobin (Hgb) 11) first trimester, Hct 32 (Hgb10) second or third trimester;
  - (C) Pre-gravida weights under 100 lbs or over 200 lbs;
  - (D) Pregnancy weight gain outside WIC guidelines;
  - (E) Eating disorder;
  - (F) Gestational diabetes;
  - (G) Hyperemesis;
  - (H) Pregnancy induced hypertension (preeclampsia);
  - (I) Other conditions identified by the maternity case manager, physician, or perinatal care provider for which adequate services are not accessible through another program.
- (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 Contact -- A non-face-to-face client encounter between a maternity case manager and the client, initiated by the maternity case manager, providing education or training related to the CSP.

(7) Maternity Case Manager Qualifications:

(a) Maternity case managers must be:

(A) Currently licensed as a:

(i) Physician;

(ii) Physician Assistant;

(iii) Nurse Practitioner;

(iv) Certified Nurse Midwife;

(v) Direct Entry Midwife;

(vi) Social Worker; or

(vii) Registered Nurse with a minimum of two years related and relevant work experience.

(B) Other para-professionals (including Community Health Representatives (CHR) under the supervision of one of the above practitioners, or a licensed direct entry midwife) may provide specific services while working under the supervision of one of the practitioners listed in (7)(a)(A) of this rule.

(b) Specific services not within the recognized scope of practice of the provider of MCM services must be referred to an appropriate discipline.

(8) Nutritional Counselor Qualifications -- A nutritional counselor 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.

(9) Documentation Requirements:

(a) Documentation is required for all MCM services in accordance with OMAP General Rules 410-120-1360;

(b) A correctly completed OMAP form 2470, 2471, and 2472 or their equivalents meet minimum documentation requirements for MCM services.

(10) Initial Assessment:

(a) Includes:

(A) Client assessment as outlined in the "Definitions" section of this rule;

(B) Development of a CSP which addresses needs identified;

(C) Making referrals as needed;

(D) Assisting with a referral to a prenatal care provider as needed;

(E) Forwarding of the initial assessment and other relevant information to the on-going maternity case manager and prenatal care provider;

(F) Communicating pertinent information to other professionals participating in the clients' medical and social care.

(b) Client's record must reflect the date and to whom the initial assessment was sent.

(11) 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) Training, information, and education contained in Table 146-0120-1;

(f) Linkage to labor and delivery services;

(g) Linkage to family planning services as needed;

(h) CSP coordination as follows:

(A) Contact with Department of Human Services worker, if assigned;

(B) Contact with prenatal care provider; and

(C) Contact with other community resources/agencies to address needs.

(i) Advocate for client 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;

(j) 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.

(12) Nutritional Counseling:

(a) Available for clients who have at least one of the documented conditions listed in the "Definitions" section of this rule;

(b) Documentation must include all of the following:

(A) Nutritional assessment;

(B) Nutritional care plan; and

(C) Regular client follow-up.

(13) Home/Environment Assessment -- Includes an assessment of the health and safety of the client's living conditions with training and education as indicated Table 146-0120-1 and must include all topics applicable to the client.

(14) Telephone Contact -- A non-face-to-face client encounter between a maternity case manager and the client, initiated by the maternity case manager, providing education or training related to the CSP when a face-to-face case management visit is not possible or practical.

(15) Case Management Visits -- Each Case Management Visit must include an evaluation and/or revision of objectives and activities addressed in the CSP and training, information and education regarding at least two topics from Table 146-0120-1.

Table: 146-0120-1

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

October 1, 2003

## Table 146-0120-1 MCM Education, Training and Prevention Topics

### Client Service Plan

<p><i>Training &amp; Education</i> <i>Maternal/Fetal HIV Transmission</i> <i>Fetal Alcohol Syndrome</i> Prevention Early Childhood Caries <i>Maternal Oral Health</i> Prevention for Tobacco Use Lead Exposure and Screening Immunizations</p>
--

### ***Environmental Assessment***

<p><b>General Assessment</b> <b><i>General Condition of House</i></b> Adequacy of Shelter Food Storage/Preparation Facilities Health Adequacy: Safety &amp; Sanitation Heating/Cooling/Ventilation Number of Bedrooms vs. People Running water Phone service Sanitation/Sewer Environmental Hazards Toxins/Teratogens</p>
---

<p><b><i>Safety</i></b> Guns: Locked and Unloaded Smoke Alarm: Installed &amp; Working Fire Prevention: i.e. smoking habits, if applicable Adequate Exits: All locations &amp; free of obstacles <b><i>Toxins</i></b> Lead Exposure: Peeling paint, lead pipes/dust Chemical Use: In or near home Asbestos <b><i>Pet</i></b> Cats (Toxoplasmosis) Birds (Psittacosis) Reptiles (Salmonella): iguanas/turtles/snakes</p>
---

**Table 146-0120-1 MCM Education, Training and Prevention Topics**

**Case Management Visits**

<p><b>Pre-term birth prevention</b>                      Factors associated with increased risk                      Early detection of symptoms                      Obtaining help/information                      Stress reduction                      Oral Health Status</p>	<p><b>Emotional</b>                      Stress reduction                      Coping strategies                      Hormonal changes                      Relationships</p>
<p><b>Pregnancy &amp; Childbirth</b>                      Common discomforts                      Pregnancy danger signs &amp; symptoms                      Labor and birth process                      Coping strategies                      Common interventions                      Emergencies</p>	<p><b>Other</b>                      Family planning                      Sexually Transmitted Diseases                      Substance/alcohol use</p>
<p><b>Health status</b>                      Rest/exercise                      Digestive tract changes                      Weight gain                      Food availability                      Food selection/preparation                      Nutrition                      Nutrient/calorie intake                      Medications</p>	<p><b>Infant Care/Parenting</b>                      Feeding/nutrition/infant growth                      Clothing needs                      Infant sleep patterns and location                      Wellness care/immunizations                      Prevention of Early Childhood Cavities                      Breastfeeding                      SIDS and Back To Sleep                      Developmental milestones                      Common interventions                      Emergencies</p>
<p><b>Environment</b>                      Health Adequacy,                      Safety and Sanitation                      Environmental Hazards                      Toxins/Teratogens                      Fluoridated Water Area</p>	<p><b>Safety</b>                      Infant/parent interaction                      Bonding/attachment                      Infant communication patterns/cues                      Parental frustration/sleep deprivation                      Household management support                      Community resources                      Child nurturing/protection</p>

**October 1, 2003**

## **410-146-0130 Modifiers**

(1) The Office of Medical Assistance Programs (OMAP) uses nationally recognized modifiers for many services. The modifiers listed in the American Indian/Alaska Native (AI/AN) billing rules are required.

(2) Refer to OAR 410-146-0080 Billing Codes Table 146-0080-1 for list of required modifiers.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

October 1, 2003

## **410-146-0140 Tobacco Cessation**

(1) AI/AN Health Care Facilities are eligible under the MOA for reimbursement for tobacco cessation services. These services are billed on a CMS-1500 using diagnosis code 305.1 only and either S9075 or G9016 as appropriate.

(2) Follow criteria outlined in OAR 410-130-0190.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02

## **410-146-0160 Administrative Medical Examinations and Reports**

(1) Administrative medical examinations and reports are not eligible under the Memorandum of Agreement (MOA). Reimbursement for administrative examinations and reports are through the Office of Medical Assistance Programs (OMAP) fee-for-service program. Do not use the American Indian/Alaska Native (AI/AN) Health Care Facility encounter code or rate for these services.

(2) AI/AN Health Care Facilities can be reimbursed for administrative medical examinations and reports when requested by a DHS branch office, or approved by OMAP. The branch office may request an Administrative Medical Examination/Report Authorization (OMAP 729) to establish client eligibility for an assistance program or casework planning.

(3) Administrative medical examinations are billed on a CMS-1500 using V68.89 as the diagnosis only and the OMAP unique procedure code that represents the exam provided.

(4) See the Administrative Examination and Report Billing guide for more detailed information on procedure codes and descriptions.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02

## **410-146-0180 Durable Medical Equipment and Medical Supplies**

(1) Durable Medical Equipment (DME) and Medical Supplies are not eligible under the Memorandum of Agreement (MOA).

Reimbursement for DME services are through the Office of Medical Assistance Programs (OMAP) fee-for-service program. Do not use the American Indian/Alaska Native (AI/AN) Health Care Facility encounter code or rate for these services.

(2) If an AI/AN Pharmacy is also supplying DME and Medical Supplies the pharmacy must also enroll as an OMAP DME provider. Follow the guidelines in the DMEPOS guide for billing and prior authorization of these items and services.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01

## **410-146-0200 Pharmacy**

(1) Pharmacy services are not eligible under the Memorandum of Agreement (MOA). Reimbursement for pharmacy services are through the Office of Medical Assistance Programs (OMAP) fee-for-service program.

(2) Do not use the American Indian/Alaska Native (AI/AN) Health Care Facility encounter code or rate for these services. AI/AN pharmacy providers use the Pharmacy guide for a complete listing of all rules and policies.

(3) Follow criteria outlined in the following:

(a) Not Covered Services -- OAR 410-121-0147;

(b) Brand Name Pharmaceuticals -- OAR 410-121-0155;

(c) Drugs and Products Requiring Prior Authorization -- OAR 410-121-0040;

(d) Prior Authorization Procedures -- OAR 410-121-0060;

(e) Clozapine Therapy -- OAR 410-121-0190;

(f) Notation on Prescription -- OAR 410-121-0144.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 59-2002, f. & cert. ef. 10-1-02

## **410-146-0220 Death With Dignity**

(1) Death With Dignity is a covered service, except for those facilities limited by the Assisted Suicide Funding Restriction Act of 1997 (ASFRA), and is incorporated in the "comfort care" condition/treatment line on the Health Services Commission's Prioritized List of Health Services.

(2) 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.

(3) Follow criteria outlined in OAR 410-130-0670.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 22-1999(Temp), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 28-1999, f. & cert. ef. 6-4-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 59-2002, f. & cert. ef. 10-1-02

## **410-146-0240 Transportation**

(1) American Indian/Alaska Native (AI/AN) Health Care Facilities can be reimbursed for medically appropriate transportation services provided to clients who are eligible for medical assistance and receive health services through an AI/AN Health Care Facility.

(2) Transportation is outside of the Memorandum of Agreement (MOA) encounter rate and must be billed to the Office of Medical Assistance Programs (OMAP) fee-for-service on a CMS-1500 billing form with a diagnosis code. Enrolled AI/AN Health Care Facilities providing medical transportation will not be enrolled as a transportation provider. When billing for an approved transportation service use the AI/AN Health Care Facility provider number.

(3) Use the HCPCS code listed in the AI/AN billing guide that represents the transportation service provided. Do not use the AI/AN Health Care Facility encounter code or rate but rather the HCPCS or OMAP unique procedure code and rate listed for each service. Non-emergency ambulance, air ambulance, commercial air, bus, or train requires advance arrangement and prior approval through the local Seniors and People with Disabilities (SPD) (formerly SDSD) or Children, Adults and Families (CAF) (formerly AFS) branch office.

(4) Reimbursement for transportation is based on the following conditions:

(a) The car/van or wheelchair car/van is owned or leased by the AI/AN Health Care Facility;

(b) The individual providing the service is an employee of the AI/AN Health Care Facility;

(c) The service to be provided is the most cost effective method that meets the medical needs of the client;

(d) The service to be provided at the point of origin and/or destination is a medical service covered under OMAP or the MOA.

(5) The following information must be documented in the client's record or a single ledger that contains all medical transportation services for all clients of the facility:

(a) Trip information including date of service, if one way, round trip, or three-way and if transportation needs are ongoing;

(b) Client information, for example, requires wheelchair, walker, cane, needs assistance, requires portable oxygen, etc.

(6) Use the appropriate HCPCS code listed in the AI/AN billing guide to bill for transportation services.

(7) Tribal facility owned or leased car/van (sedan transport):

(a) When client circumstance requires an escort or attendant or when a second client is transported from the same point of origin to the same destination, no additional charge beyond the actual mileage is allowed;

(b) If more than one client is transported from a single pickup point to different destinations or from different pickup points to the final destination the total mileage may be billed. No duplicated miles traveled may be billed;

(c) A0170 All inclusive rate -- \$1.19 per mile.

(8) Tribal facility owned/leased wheelchair car/van (sedan transport):

(a) If a client is able to transfer from wheelchair to car/van use the car/van all-inclusive service. If two OMAP clients are transported by the same mode (e.g., wheelchair van) at the same time, OMAP will reimburse at the full base rate for the first client and one-half the appropriate base rate for each additional client. If two or more OMAP clients are transported by mixed mode (e.g., wheelchair van and ambulatory) at the same time, OMAP will reimburse at the full base rate for the highest mode for the first client and one-half the base rate of the appropriate mode for each additional client. Reimbursement will not be made for duplicated miles traveled. If more than one client

is transported from a single pickup point to different destinations or from different pickup points to the final destination the total mileage may be billed. The first 10 miles is included in the Base Rate and should be included in the total number of miles on the CMS-1500:

(A) A0130 -- Base Rate: \$17.72;

(B) T2002 -- Mileage (each way): \$1.19 per mile. The first 10 miles are included in the Base Rate. When billing mileage, place the total number of miles in Field 24G and the OMAP system will automatically deduct 10 miles;

(C) T2001 -- Extra Attendant (each): \$17.72.

(b) When billing for transportation use TOS code "D" and the appropriate POS code listed below:

(A) E -- Home to Medical Practitioner;

(B) F -- Home to Hospital;

(C) G -- Home to Nursing Facility;

(D) H -- Home to Other;

(E) J -- Nursing Facility to Medical Practitioner;

(F) K -- Nursing Facility to Hospital;

(G) L -- Nursing Facility to Home;

(H) M -- Nursing Facility to Other;

(I) N -- Hospital to Home;

(J) P -- Hospital to Nursing Facility;

(K) Q -- Hospital to Other Hospital;

(L) R -- Hospital to Other;

(M) S -- Medical Practitioner to Hospital;

(N) T -- Medical Practitioner to Nursing Facility;

(O) U -- Medical Practitioner to Home;

(P) V -- Medical Practitioner to Other;

(Q) W -- Other to Hospital;

(R) X -- Other to Other.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 14-2002, f. & cert. ef. 4-1-02; OMAP 59-2002, f. & cert. ef. 10-1-02

## **410-146-0340 Medicare/Medical Assistance Program Claims**

(1) If a client has both Medicare and Medical Assistance Program coverage, providers must bill Medicare first. Medicare will automatically forward all claims to the Office of Medical Assistance Programs (OMAP) for processing. However, since American Indian/Alaska Native (AI/AN) Health Care Facilities must bill OMAP using the most appropriate code as described in the AI/AN billing guide, some of these claims may not be processed and paid automatically. If your claim cannot be paid and processed automatically, a Remittance Advice instructing you to rebill OMAP on the CMS-1500 claim form will be sent to you.

(2) If an out-of-state Medicare carrier or intermediary was billed, you must bill OMAP using a CMS-1500 claim form, but only after that carrier has made payment determination.

(3) When rebilling on the CMS-1500, bill all services for each encounter under the most appropriate code as directed in the AI/AN billing guide. Enter any Medicare payment received in the "Amount Paid" field or use the appropriate TPR explanation code in Field 9 of the CMS-1500 claim form. See billing instructions for details.

(4) OMAP payment will be based on the allowable cost per encounter, less the actual Medicare payment amount.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02