Division of Medical Assistance Programs
Policy and Planning Section

General Rules Administrative Rulebook

Chapter 410, Division 120

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410-120-0000 – Acronyms and Definitions

Identification of acronyms and definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division), or the Addictions and Mental Health Division (AMH) administrative rules, applicable to the medical assistance program. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program OAR 410-141-0000, Acronyms and Definitions; 410-200-0015, General Definitions; and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 411 or 413 administrative rules; or contact the Division.

(1) “Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Authority or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Authority.

(2) “Acupuncturist” means a person licensed to practice acupuncture by the relevant state licensing board.

(3) “Acupuncture Services” means services provided by a licensed acupuncturist within the scope of practice as defined under state law.

(4) “Acute” means a condition, diagnosis, or illness with a sudden onset and that is of short duration.

(5) “Acquisition Cost” means, unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply, or equipment plus any shipping or postage for the item.

(6) “Addiction and Mental Health Division (AMH)” means a division within the Authority that administers mental health and addiction programs and services.

(7) “Adequate Record Keeping” means documentation that supports the level of service billed. See 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.

(8) “Administrative Medical Examinations and Reports” means examinations, evaluations, and reports, including copies of medical records, requested on the DMAP 729 form through the local Department branch office or requested or approved by the Authority to establish client eligibility for a medical assistance program or for casework planning.

(9) “Advance Directive” means an individual’s instructions to an appointed person specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.

(10) “Adverse Event” means an undesirable and unintentional, though not unnecessarily unexpected, result of medical treatment.

(11) “Aging and People with Disabilities (APD)” means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities. This division was formerly named “Seniors and People with Disabilities (SPD).”

(12) “All-Inclusive Rate” or “Bundled Rate” means the nursing facility rate established for a facility. This rate includes all services, supplies, drugs, and equipment as described in OAR 411-070-0085 and in the Division’s Pharmaceutical Services program administrative rules and the Home Enteral/Parenteral Nutrition and IV Services program administrative rules, except as specified in OAR 410-120-1340, Payment.

(13) “Allied Agency” means local and regional governmental agency and regional authority that contracts with the Authority or Department to provide the delivery of services to covered individuals (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, area agencies on aging (AAAs), federally recognized American Indian tribes).

(14) “Alternative Care Settings” means sites or groups of practitioners that provide care to members under contract with a PHP or CCO, including urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, long-term care facilities, and outpatient surgical centers.

(15) “Ambulance” means a specially equipped and licensed vehicle for transporting sick or injured persons that meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.

(16) “Ambulatory Payment Classification” means a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs).

(17) “Ambulatory Surgical Center (ASC)” means a facility licensed as an ASC by the Authority.

(18) “American Indian/Alaska Native (AI/AN)” means a member of a federally recognized Indian tribe, band, or group, and an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims

Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.

(19) “American Indian/Alaska Native (AI/AN) Clinic” means a clinic recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).

(20) “Ancillary Services” means services supportive of or necessary for providing a primary service, such as anesthesiology, which is an ancillary service necessary for a surgical procedure.

(21) “Anesthesia Services” means administration of anesthetic agents to cause loss of sensation to the body or body part.

(22) “Area Agency on Aging (AAA)” means the designated entity with which the Department contracts to meet the requirements of the Older Americans Act and ORS Chapter 410 in planning and providing services to the elderly or elderly and disabled population.

(23) “Atypical Provider” means an entity able to enroll as a billing provider (BP) or rendering provider for medical assistance programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.

(24) “Audiologist” means a person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.

(25) “Audiology” means the application of principles, methods, and procedures of measurement, testing, appraisal, prediction, consultation, counseling, and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.

(26) “Automated Voice Response (AVR)” means a computer system that provides information on clients' current eligibility status from the Division by computerized phone or web-based response.

(27) “Benefit Package” means the package of covered health care services for which the client is eligible.

(28) “Billing Agent or Billing Service” means third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.

(29) “Billing Provider (BP)” means a person, agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider.

(30) “Buying Up” means the practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See 410-120-1350 Buying Up.)

(31) “By Report (BR)": means services designated, as BR requires operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care will facilitate evaluation.

(32) “Case Management Services” means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies.

(33) “Child Welfare (CW)” means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.

(34) “Children's Health Insurance Program (CHIP)” means a federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.

(35) “Chiropractor” means a person licensed to practice chiropractic by the relevant state licensing board.

(36) “Chiropractic Services” means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.

(37) “Citizen/Alien-Waived Emergency Medical (CAWEM)” means aliens granted lawful temporary resident status or lawful permanent resident status under the Immigration and Nationality Act are eligible only for emergency services and limited service for pregnant women. Emergency services for CAWEM are defined in OAR 410-120-1210 (3)(f).

(38) “Claimant” means a person who has requested a hearing.

(39) “Client” means an individual found eligible to receive OHP health services. “Client” is inclusive of members enrolled in PHPs, PCMs, and CCOs.

(40) “Clinical Nurse Specialist” means a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.

(41) “Clinical Social Worker” means a person licensed to practice clinical social work pursuant to state law.

(42) “Clinical Record” means the medical, dental, or mental health records of a client or member.

(43) “Comfort Care” means medical services or items that give comfort or pain relief to an individual who has a terminal Illness, including the combination of medical and related services designed to make it possible for an individual with terminal Illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.

(44) “Contested Case Hearing” means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an action:

(a) A client or member or their representative;

(b) A PHP or CCO member’s provider; or

(c) A PHP or CCO.

(45) “Contiguous Area” means the area up to 75 miles outside the border of the State of Oregon.

(46) “Contiguous Area Provider” means a provider practicing in a contiguous area.

(47) “Continuing Treatment Benefit” means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day immediately before the date the client’s benefit package changed to one that does not cover the treatment.

(48) “Coordinated Care Organization (CCO)” as defined in OAR 410-141-0000.

(49) “Co-Payments” means the portion of a claim or medical, dental, or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See 410-120-1230 Client Copayment.)

(50) “Cost Effective” means the lowest cost health service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.

(51) “Cover Oregon” means the state’s health insurance exchange that will help individuals find out if they qualify for Medicaid, CHIP, or health insurance coverage for themselves, their families, and their employees.

(52) “Covered Services” means medically appropriate health services described in ORS Chapter 414 and applicable administrative rules that the legislature funds, based on the Prioritized List of Health Services.

(53) “Current Dental Terminology (CDT)” means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.

(54) “Current Procedural Terminology (CPT)” means the physicians' CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other health care providers.

(55) “Date of Receipt of a Claim” means the date on which the Authority receives a claim as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN.

(56) “Date of Service” means the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.

(57) “Dental Emergency Services” means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.

(58) “Dental Services” means services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist.

(59) “Dentist” means a person licensed to practice dentistry pursuant to state law of the state in which he or she practices dentistry or a person licensed to practice dentistry pursuant to federal law for the purpose of practicing dentistry as an employee of the federal government.

(60) “Denturist” means a person licensed to practice denture technology pursuant to state law.

(61) “Denturist Services” means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.

(62) “Dental Hygienist” means a person licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to state law.

(63) “Dental Hygienist with an Expanded Practice Permit” means a person licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to state law.

(64) “Dentally Appropriate” means services that are required for prevention, diagnosis, or treatment of a dental condition and that are:

(a) Consistent with the symptoms of a dental condition or treatment of a dental condition;

(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of the client or a provider of the service;

(d) The most cost effective of the alternative levels of dental services that can be safely provided to a client.

(65) “Department of Human Services (Department or DHS)” means the agency established in ORS Chapter 409, including such divisions, programs and offices as may be established therein.

(66) “Department Representative” means a person who represents the Department and presents the position of the Department in a hearing.

(67) “Diagnosis Code” means as identified in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(68) “Diagnosis Related Group (DRG)” means a system of classification of diagnoses and procedures based on the ICD-9-CM.

(69) “Division of Medical Assistance Programs (Division)” means a division within the Authority. The Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs.

(70) “Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)” means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches, and custom built orthopedic braces. Medical supplies are non-

reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing.

(71) “Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck)” mean the Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.

(72) “Electronic Data Interchange (EDI)” means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions. For purposes of rules 407-120-0100 through 407-120-0200, EDI does not include electronic transmission by web portal.

(73) “EDI Submitter” means an individual or an entity authorized to establish an electronic media connection with the Authority to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.

(74) “Electronic Verification System (EVS)” means eligibility information that has met the legal and technical specifications of the Authority in order to offer eligibility information to enrolled providers of the Division.

(75) “Emergency Department” means the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.

(76) “EMT Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. (This definition does not apply to clients with CAWEM benefit package. CAWEM emergency services are governed by OAR 410-120-1210(3)(f)(B)).

(77) “Emergency Medical Transportation” means transportation necessary for a client with an emergency medical condition as defined in this rule and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.

(78) “Emergency Services” means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient’s condition is not likely to materially deteriorate from or during a client’s discharge from a facility or transfer to another facility.

(79) “Evidence-Based Medicine” means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)).

(80) “False Claim” means a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading, or omitted information and such inaccurate, misleading, or omitted information would result, or has resulted, in an overpayment.

(81) “Family Planning Services” means services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and that are intended to prevent pregnancy or otherwise limit family size.

(82) “Federally Qualified Health Center (FQHC)” means a federal designation for a medical entity that receives grants under Section 329, 330, or 340 of the Public Health Service Act or a facility designated as an FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.

(83) “Fee-for-Service Provider” means a health care provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). A medical provider participating in a PHP or a CCO may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO.

(84) “Flexible Service” means a service that is an alternative or addition to a service that is as likely or more likely to effectively treat the mental condition, substance use

disorder condition, or physical condition as documented in the member's clinical record. Flexible Services may include, but are not limited to: Respite care, partial hospitalization, subacute psychiatric care, family support services, parent psychosocial skills development, peer services, and other non-traditional services identified.

(85) "Flexible Service Approach" means the delivery of any coordinated care service in a manner or place different from the traditional manner or place of service delivery. A flexible service approach may include delivering coordinated care services at alternative sites such as schools, residential facilities, nursing facilities, members' homes, emergency rooms, offices of the Department and the Authority, and other community settings offering flexible clinic hours, coordinated care services through outreach or a home-based approach, and using peers, paraprofessionals, community health workers, peer wellness specialists, or personal health navigators who are culturally competent to engage difficult-to-reach members.

(86) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(87) "Fully Dual Eligible" means for the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Department for full medical assistance coverage.

(88) "General Assistance (GA)" means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.

(89) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I — American Medical Association's Physician's Current Procedural Terminology (CPT), Level II — National codes, and Level III — Local codes. The Division uses HCPCS codes; however, the Division uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.

(90) "Health Care Professionals" means individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification.

(91) "Health Evidence Review Commission" means a commission that, among other duties, develops and maintains a list of health services ranked by priority from the most to the least important representing the comparative benefits of each service to the population served.

(92) "Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA)" means the federal law (Public Law 104-191, August 21, 1996) with the legislative

objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.

(93) “Health Maintenance Organization (HMO)” means a public or private health care organization that is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.

(94) “Health Plan New/non-categorical client (HPN)” means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program, and who must meet all eligibility requirements to become an OHP client.

(95) “Hearing Aid Dealer” means a person licensed by the Board of Hearing Aid Dealers to sell, lease, or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.

(96) “Home Enteral Nutrition” means services provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.

(97) “Home Health Agency” means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that is licensed by the Authority as a home health agency in Oregon and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.

(98) “Home Health Services” means part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the client's home.

(99) “Home Intravenous Services” means services provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.

(100) “Home Parenteral Nutrition” means services provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.

(101) “Hospice” means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice

services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation and is currently licensed by the Oregon Health Authority (Authority), Public Health Division.

(102) “Hospital” means a facility licensed by the Office of Public Health Systems as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as long-term care hospitals, long-term acute care hospitals, or religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals will be considered hospitals for reimbursement purposes if they are licensed as a short term acute care or general hospital by the appropriate licensing authority within that state and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.

(103) “Hospital-Based Professional Services” means professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (division 42) report for the Division.

(104) “Hospital Dentistry” means dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).

(105) “Hospital Laboratory” means a laboratory providing professional technical laboratory services as outlined under laboratory services in a hospital setting as either an inpatient or outpatient hospital service whose costs are reported on the hospital's cost report to Medicare and to the Division.

(106) “Indian Health Care Provider” means an Indian health program or an urban Indian organization.

(107) “Indian Health Program” means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.

(108) “Indian Health Service (IHS)” means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized tribes and Alaska Natives.

(109) “Indigent” means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with-out health insurance coverage, public or private, who meet standards for indigence adopted by the federal government as defined in 813.602(5).

(110) “Individual Adjustment Request Form (DMAP 1036)” means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.

(111) “Inpatient Hospital Services” means services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)

(112) “Institutional Level of Income Standards (ILIS)” means three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program.

(113) “Institutionalized” means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing or hospital care for a period of 30 days or more.

(114) “International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (including volumes 1, 2, and 3, as revised annually)” means a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.

(115) “Laboratory” means a facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare and to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials 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. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory under the Clinical Laboratory Improvement Act (CLIA).

(116) “Laboratory Services” means those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within his or her scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent laboratory.

(117) “Licensed Direct Entry Midwife” means a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division.

(118) “Liability Insurance” means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner’s liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.

(119) “Managed Care Organization (MCO)” means a contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).

(120) “Maternity Case Management” means a program available to pregnant clients. The purpose of maternity case management is to extend prenatal services to include non-medical services that address social, economic, and nutritional factors. For more information refer to the Division’s Medical-Surgical Services program administrative rules.

(121) “Medicaid” means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.

(122) “Medical Assistance Eligibility Confirmation” means verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.

(123) “Medical Assistance Program” means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project and Medicaid and CHIP services under the State Plan.

(124) “Medical Care Identification” means the card commonly called the “medical card” or medical ID issued to clients (called the Oregon Health ID starting Aug. 1, 2012).

(125) “Medical Services” means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.

(126) “Medical Transportation” means transportation to or from covered medical services.

(127) “Medically Appropriate” means services and medical supplies that are required for prevention, diagnosis, or treatment of a health condition that encompasses physical or mental conditions or injuries and that are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, evidence-based medicine, and professional standards of care as effective;

(c) Not solely for the convenience of an OHP client or a provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to a Division client or Primary Care Manager (PCM) member in the PHP's or PCM's judgment.

(128) "Medicare" means a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:

(a) Hospital Insurance (Part A) for inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; and

(b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies;

(c) Prescription drug coverage (Part D) means covered Part D drugs that include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act. It also includes medical supplies associated with the injection of insulin. Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). For limitations, see the Division's Pharmaceutical Services program administrative rules in chapter 410, division 121.

(129) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.

(130) "Medicheck for Children and Teens" means services also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The Title XIX program of EPSDT services is for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.

(131) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.

(132) "Mental Health Case Management" means services provided to CCO members who require assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers. Services provided may include: Advocating for the CCO member's treatment needs; providing assistance in obtaining entitlements based on mental or emotional disability; referring CCO members to needed services or supports; accessing housing or residential programs; coordinating services, including educational or vocational activities; and establishing alternatives to inpatient psychiatric services.

(133) “National Correct Coding Initiative (NCCI)” means the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.

(134) “National Drug Code or (NDC)” means a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the remaining digits to identify the specific product and package size. Some packages will display less than 11 digits, but the number assumes leading zeroes.

(135) “National Provider Identification (NPI)” means federally directed provider number mandated for use on HIPAA covered transactions; individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI. Medicare covered entities are required to apply for an NPI.

(136) “Naturopathic physician” means a person licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.

(137) “Naturopathic Services” means services provided within the scope of practice as defined under state law and by rules of the Oregon Board of Naturopathic Medicine..

(138) “Non-covered Services” means services or items for which the Authority is not responsible for payment or reimbursement. Non-covered services are identified in:

(a) OAR 410-120-1200, Excluded Services and Limitations; and

(b) 410-120-1210, Medical Assistance Benefit Packages and Delivery System;

(c) 410-141-0480, OHP Benefit Package of Covered Services;

(d) 410-141-0520, Prioritized List of Health Services; and

(e) Any other applicable Division administrative rules.

(139) “Non-Emergent Medical Transportation Services (NEMT)”means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000(76) and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.

(140) “Non-Paid Provider” means a provider who is issued a provider number for purposes of data collection or non-claims-use of the Provider Web Portal (e.g., eligibility verification).

(141) “Nurse Anesthetist, C.R.N.A.” means a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.

(142) “Nurse Practitioner” means a person licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to state law.

(143) “Nurse Practitioner Services” means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing.

(144) “Nursing Facility” means a facility licensed and certified by the Department and defined in OAR 411-070-0005.

(145) “Nursing Services” means health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by state law.

(146) “Nutritional Counseling” means counseling that takes place as part of the treatment of a person with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria.

(147) “Occupational Therapist” means a person licensed by the State Board of Examiners for Occupational Therapy.

(148) “Occupational Therapy” means the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, the aging process, or psychological disability. The treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.

(149) “Ombudsman Services” means advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of, or limitations on the health services provided.

(150) “Oregon Health ID” means a card the size of a business card that lists the client name, client ID (prime number), and the date it was issued.

(151) “Oregon Health Plan (OHP)” means the Medicaid and Children’s Health Insurance (CHIP) Demonstration Project that expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations and Medicaid and CHIP services under the State Plan

(152) “Optometric Services” means services provided within the scope of practice of optometrists as defined under state law.

(153) “Optometrist” means a person licensed to practice optometry pursuant to state law.

(154) “Oregon Health Authority (Authority)” means the agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the Oregon Health Authority are the Public Health Division, the Addictions and Mental Health Division, and the Division of Medical Assistance Programs.

(155) “Oregon Youth Authority (OYA)” means the state department charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth corrections.

(156) “Out-of-State Providers” means any provider located outside the borders of the State of Oregon:

(a) Contiguous area providers are those located no more than 75 miles from the border of the State of Oregon;

(b) Non-contiguous area providers are those located more than 75 miles from the borders of the State of Oregon.

(157) “Outpatient Hospital Services” means services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division’s Hospital Services administrative rules found in chapter 410, division 125.

(158) “Overdue Claim” means a valid claim that is not paid within 45 days of the date it was received.

(159) “Overpayment” means a payment made by the Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.

(160) “Overuse” means use of medical goods or services at levels determined by Authority medical staff or medical consultants to be medically unnecessary or potentially harmful.

(161) “Paid Provider” means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.

(162) “Panel” means the Hearing Officer Panel established by section 3, chapter 849, Oregon Laws 1999.

(163) “Payment Authorization” means authorization granted by the responsible agency, office, or organization for payment prior or subsequent to the delivery of services, as described in these General Rules and the appropriate program rules. See the individual program rules for services requiring authorization.

(164) “Peer Review Organization (PRO)” means an entity of health care practitioners of services contracted by the state to review services ordered or furnished by other practitioners in the same professional field.

(165) “Pharmaceutical Services” means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within his or her scope of practice.

(166) “Pharmacist” means a person licensed to practice pharmacy pursuant to state law.

(167) “Physical Capacity Evaluation” means an objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the person.

(168) “Physical Therapist” means a person licensed by the relevant state licensing authority to practice physical therapy.

(169) “Physical Therapy” means treatment comprising exercise, massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis, or treatment of a human being. Physical therapy may not include radiology or electrosurgery.

(170) “Physician” means a person licensed to practice medicine pursuant to state law of the state in which he or she practices medicine or a person licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or ORS 685.

(171) “Physician Assistant” means a person licensed as a physician assistant in accordance with ORS 677. Physician assistants provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.

(172) “Physician Services” means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.

(173) “Podiatric Services” means services provided within the scope of practice of podiatrists as defined under state law.

(174) “Podiatrist” means a person licensed to practice podiatric medicine pursuant to state law.

(175) “Post-Payment Review” means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons subsequent to payment of the claim.

(176) “Practitioner” means a person licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification.

(177) “Premium Sponsorship” means premium donations made for the benefit of one or more specified Division clients (See 410-120-1390).

(178) “Prepaid Health Plan (PHP)” means a managed health, dental, chemical dependency, or mental health organization that contracts with the Authority on a case managed, prepaid, capitated basis under OHP. PHPs may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO), or Physician Care Organization (PCO)

(179) “Primary Care Dentist (PCD)” means a dental practitioner who is responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.

(180) “Primary Care Provider (PCP)” means any enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultations, and specialist care and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005.

(181) “Prior Authorization (PA)” means payment authorization for specified medical services or items given by Authority staff or its contracted agencies prior to provision of the service. A physician referral is not a PA.

(182) “Prioritized List of Health Services” means the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP.

(183) “Private Duty Nursing Services” means nursing services provided within the scope of license by a registered nurse or a licensed practical nurse under the general direction of the patient's physician to an individual who is not in a health care facility.

(184) “Provider” means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or

bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.

(185) “Provider Organization” means a group practice, facility, or organization that is:

(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or

(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or

(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and

(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization;

(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. (See Subparts of Provider Organization.)

(186) “Public Health Clinic” means a clinic operated by a county government.

(187) “Public Rates” means the charge for services and items that providers, including hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to Authority clients.

(188) “Qualified Medicare Beneficiary (QMB)” means a Medicare beneficiary as defined by the Social Security Act and its amendments.

(189) “Qualified Medicare and Medicaid Beneficiary (QMM)” means a Medicare beneficiary who is also eligible for Division coverage.

(190) “Quality Improvement” means the efforts to improve the level of performance of a key process or processes in health services or health care.

(191) “Quality Improvement Organization (QIO)” means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid clients; formerly known as a Peer Review Organization.

(192) “Radiological Services” means those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a

physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent radiological facility.

(193) “Recipient” means a person who is currently eligible for medical assistance (also known as a client).

(194) “Recreational Therapy” means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).

(195) “Recoupment” means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a provider's future payments.

(196) “Referral” means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority.

(197) “Remittance Advice (RA)” means the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions.

(198) “Rendering provider” means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.

(199) “Request for Hearing” means a clear expression in writing by an individual or representative that the person wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.

(200) “Representative” means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.

(201) “Retroactive Medical Eligibility” means eligibility for medical assistance granted to a client retroactive to a date prior to the client's application for medical assistance.

(202) “Ride” means non-emergent medical transportation services for a client either to or from a location where covered services are provided. “Ride” does not include client-reimbursed medical transportation or emergency medical transportation in an ambulance.

(203) “Rural” means a geographic area that is ten or more map miles from a population center of 30,000 people or less.

(204) “Sanction” means an action against providers taken by the Authority in cases of fraud, misuse, or abuse of Division requirements.

(205) “School Based Health Service” means a health service required by an Individualized Education Plan (IEP) during a child's education program that addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.

(206) “Self-Sufficiency” means the division in the Department of Human Services (Department) that administers programs for adults and families.

(207) “Service Agreement” means an agreement between the Authority and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.

(208) “Sliding Fee Schedule” means a fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.

(209) “Social Worker” means a person licensed by the Board of Clinical Social Workers to practice clinical social work.

(210) “Speech-Language Pathologist” means a person licensed by the Oregon Board of Examiners for Speech Pathology.

(211) “Speech-Language Pathology Services” means the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.

(212) “State Facility” means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.

(213) “Subparts (of a Provider Organization)” means for NPI application, subparts of a health care provider organization would meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically or has an entity do so on its behalf and could be components of an organization or separate physical locations of an organization.

(214) “Subrogation” means right of the state to stand in place of the client in the collection of third party resources (TPR).

(215) “Supplemental Security Income (SSI)” means a program available to certain aged and disabled persons that is administered by the Social Security Administration through the Social Security office.

(216) “Surgical Assistant” means a person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(217) “Suspension” means a sanction prohibiting a provider's participation in the medical assistance programs by deactivation of the provider's Authority-assigned billing number for a specified period of time. No payments, Title XIX, or State Funds will be made for services provided during the suspension. The number will be reactivated automatically after the suspension period has elapsed.

(218) “Targeted Case Management (TCM)” means activities that will assist the client in a target group in gaining access to needed medical, social, educational, and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by allied agency providers.

(219) “Termination” means a sanction prohibiting a provider's participation in the Division’s programs by canceling the provider's Authority-assigned billing number and agreement. No payments, Title XIX, or state funds will be made for services provided after the date of termination. Termination is permanent unless:

(a) The exceptions cited in 42 CFR 1001.221 are met; or

(b) Otherwise stated by the Authority at the time of termination.

(220) “Third Party Liability (TPL), Third Party Resource (TPR), or Third party payer” means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client.

(221) “Transportation” means medical transportation.

(222) “Type A Hospital” means a hospital identified by the Office of Rural Health as a Type A hospital.

(223) “Type B AAA” means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services, and regulatory programs for the elderly or the elderly and disabled.

(224) “Type B AAA Unit” means a Type B AAA funded by Oregon Project Independence (OPI), Title III—Older Americans Act, and Title XIX of the Social Security Act.

(225) “Type B Hospital” means a hospital identified by the Office of Rural Health as a Type B hospital.

(226) “Urban” means a geographic area that is less than ten map miles from a population center of 30,000 people or more.

(227) “Urgent Care Services” means health services that are medically appropriate and immediately required to prevent serious deterioration of a client’s health that are a result of unforeseen illness or injury.

(228) “Usual Charge (UC)” means the lesser of the following unless prohibited from billing by federal statute or regulation:

(a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;

(b) The provider's lowest charge per unit of service on the same date that is advertised, quoted, or posted. The lesser of these applies regardless of the payment source or means of payment;

(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200 percent of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to third party resources (TPR) are to be considered.

(229) “Utilization Review (UR)” means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.

(230) “Valid Claim” means an invoice received by the Division or the appropriate Authority or Department office for payment of covered health care services rendered to an eligible client that:

(a) Can be processed without obtaining additional information from the provider of the goods or services or from a TPR; and

(b) Has been received within the time limitations prescribed in these General Rules (OAR 410 division 120).

(231) “Vision Services” means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

(232) “Volunteer” (for the purposes of NEMT) means an individual selected, trained and under the supervision of the Department who is providing services on behalf of the Department in a non-paid capacity except for incidental expense reimbursement under the Department Volunteer Program authorized by ORS 409.360.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-120-0003 – OHP Standard Benefit Package

The OHP Standard benefit package is eliminated effective January 1,2 014. Although references to OHP Standard exist elsewhere in rule, the benefit package currently is not funded and is not offered as a benefit. Those enrolled in OHP Standard are enrolled in other existing benefit packages.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.706

410-120-0006 – Medical Eligibility Standards

As the state Medicaid and CHIP agency, the Oregon Health Authority (Authority) is responsible for establishing and implementing eligibility policies and procedures consistent with applicable law. As outlined in OAR 943-001-0020, the Authority and the Department of Human Services (Department) work together to adopt rules to assure that medical assistance eligibility procedures and determinations are consistent across both agencies.

(1) The Authority adopts and incorporates by reference the rules established in OAR Chapter 461 for all overpayment, personal injury liens and estates administration for Authority programs covered under OAR chapter 410, division 200.

(2) Any reference to OAR chapter 461 in contracts of the Authority are deemed to be references to the requirements of this rule and shall be construed to apply to all eligibility policies, procedures and determinations by or through the Authority.

(3) For purposes of this rule, references in OAR chapter 461 to the Department or to the Authority shall be construed to be references to both agencies.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042, 414.065

410-120-0025 – Administration of Division of Medical Assistance Programs, Regulation and Rule Precedence

(1) The Oregon Health Authority (Authority) and its Division of Medical Assistance Programs (Division), may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of medical assistance programs including the Oregon Health Plan pursuant to ORS 414.065 (generally, fee-for-service), 414.651(Coordinated Care Organizations), and 414.115 to 414.145 (services contracts) subject to the rulemaking requirements of Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.

(2) In applying its policies, procedures, rules and interpretations, the Division shall construe them as much as possible to be complementary. In the event that Division policies, procedures, rules and interpretations may not be complementary, the Division shall apply the following order of precedence to guide its interpretation:

(a) For purposes of the provision of covered medical assistance to Division clients, including but not limited to authorization and delivery of service, or denials of authorization or services, the Division, clients, enrolled providers and the Prepaid Health Plans must apply the following order of precedence:

(A) Oregon Revised Statutes governing medical assistance programs;

(B) Consistent with ORS 413.071,those federal laws and regulations governing the operation of the medical assistance program and any waivers granted the Authority by the Centers for Medicare and Medicaid Services to operate medical assistance programs including the Oregon Health Plan;

(C) Generally for Prepaid Health Plans, requirements applicable to the provision of covered medical assistance to Division clients are provided in OAR 410-141-0000 through 410-141-0860, Oregon Health Plan Administrative Rules for Prepaid Health Plans, inclusive, and where applicable, Division General Rules, 410-120-0000 through 410-120-1980, and the provider rules applicable to the category of medical service;

(D) Generally for enrolled fee-for-service providers or other contractors, requirements applicable to the provision of covered medical assistance to Division clients are provided in Division General Rules, OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage described in 410-141-0480 to 410-141-0520, and the provider rules applicable to the category of medical service;

(E) Any other applicable duly promulgated rules issued by the Division and other offices or units within the Oregon Health Authority or Department of Human Services necessary to administer the State of Oregon’s medical assistance

programs, such as electronic data transaction rules in OAR 943-120-0100 to 943-120-0200; and

(F) The basic framework for provider enrollment in OAR 943-120-0300 through 943- 120-0380 generally apply to providers enrolled with the Authority or Department, subject to more specific requirements applicable to the administration of the Oregon Health Plan and medical assistance programs administered by the Authority. For purposes of this rule, “more specific” means the requirements, laws and rules applicable to the provider type and covered services described in subsections (A) – (E) of this section.

(b) For purposes of contract administration solely as between the Authority and its Prepaid Health Plans, the terms of the applicable contract and the requirements in subsection (2)(a) of this rule applicable to the provision of covered medical assistance to Division clients.

(A) Nothing in this rule shall be deemed to incorporate into contracts provisions of law not expressly incorporated into such contracts, nor shall this rule be deemed to supersede any rules of construction of such contracts that may be provided for in such contracts.

(B) Nothing in this rule gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly or indirectly or otherwise, to any person or entity unless such person or entity is identified by name as a named party to the contract.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-120-0030 – Children's Health Insurance Program

(1) The Children's Health Insurance Program (CHIP) is a federal non-entitlement program. The Oregon Health Authority (Authority), Division of Medical Assistance Program (Division) administers two programs funded under CHIP in accordance with the Oregon Health Plan (OHP) waiver and the CHIP state plan.

(a) CHIP: Provides health coverage for uninsured, low-income children who are ineligible for Medicaid;

(b) CHIP Pre-natal care expansion program.

(2) The General Rules Program (OAR 410-120-0000 et. seq.) and the OHP Program rules (OAR 410-141-0000 et. seq.) applicable to the Medicaid program are also applicable to the Authority's CHIP program.

(3) Children under 19 years of age who meet the income limits, citizenship requirements and eligibility criteria for medical assistance established in OAR chapter 410 through the program acronym OHP-CHP, receive the OHP benefit package (for benefits refer to OAR 410-120-1210).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-120-0035 – Public Entity

(1) This rule pertains to Centers for Medicare and Medicaid (CMS) regulations for payments to and from the Oregon Health Authority (Authority) and public entities.

(2) Effective July 1, 2008, unit of government providers responsible by rule or contract for the local match share portion for claims eligible for Federal Financial Participation (FFP) submitted to Medicaid for reimbursement must submit the local match payment prior to the Authority claiming the federal share from CMS:

(a) Before the provider submits its claims to the Authority, the provider must transfer funds from allowable sources to the Authority representing the local match share of the total allowable cost for claimed services;

(b) Upon receipt of provider's transfer of the local match share and the Authority receipt of claims in the Medical Management Information System (MMIS) that are reimbursable to the extent of the transferred local match share amount, the Authority will claim FFP from CMS and reimburse the provider for the total reimbursable allowable claimed amount for the services;

(c) Transfer of the local match share to the Authority means that the provider certifies that for the purposes of 42 CFR 433.51, the funds it transfers to the Authority for the local match share are public funds that are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds; and that all sources of funds are allowable under 42 CFR 433 Subpart B.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-120-0045 – Applications for Medical Assistance at Provider locations

(1) The Oregon Health Authority (Authority) allows Division enrolled providers the opportunity to assist patients applying for public and private health coverage offered through OHA and Cover Oregon at the provider's practice site. Once the provider is determined eligible by the Authority, providers will receive an approval letter, unique assister identification number, training requirements and other information.

(2) For purposes of this rule, the provider's practice will be referred to as a site. Sites can be, but are not limited, to the following:

(a) Hospitals;

(b) Federally qualified health centers/rural health clinics (FQHC/RHCs);

(c) County health departments;

(d) Substance Use Disorder adult and adolescent treatment and recovery centers;

(e) Tribal health clinics;

(f) Family Planning clinics;

(g) Other primary care clinics as approved by the Authority.

(3) The site shall send all employees that will be assisting to a mandatory Authority training session for application assistance certification. Employees must pass a test provided at that training session before initiating application assistance service. At least one trained employee must be a permanent employee of the site. Sites shall ensure that individuals performing application assistance are recertified at appropriate times as set forth by the Authority. For purposes of this rule, certified staff will be referred to as "application assisters."

(4) Application assisters will log in to the Cover Oregon portal to provide enrollment assistance. In the event that the client needs require the use of a paper application, the Application assister will write the date the application was started and the assister's assigned assister identification number in the appropriate space on the application. Assistance will support patients potentially eligible for public and private health coverage offered through OHA and Cover Oregon. Sites are not under an obligation to provide medical program or Cover Oregon application assistance to individuals other than those they are providing care to. The application assister shall establish a date of request for applicants by logging into the Cover Oregon portal or writing the assister's identification number on the paper application in the appropriate place with the date the applicant requests an application. Once written on the application, the date can never be changed, altered or backdated. The inscription must include the provider's assigned application assister site code number, in addition to the date.

(5) The application assister shall encourage applicants to provide accurate and truthful information, assist in completing the application and enrollment process and shall assure that the information contained on the application is complete. The application assister shall not attempt to pre-determine applicant eligibility or make any assurances regarding the eligibility for public or private health coverage offered through OHA and Cover Oregon.

(6) The application assister shall provide information to applicants about public medical programs and Cover Oregon private insurance products so applicant can make an informed choice when enrolling into a health insurance product. Language (including sign language) translators must be available if requested by applicants.

(a) The information given to the applicant shall, at a minimum, include an explanation of the significance of the date of request on the hard copy application, review of public medical programs and Cover Oregon private insurance products that are available, provide unbiased health coverage choices using filters embedded in the online application and information provided by OHA or Cover Oregon during enrollment process,, answer questions and assist in filling out online or paper application forms. The information provided at these sessions may include, but is not limited to the following:

(A) General eligibility criteria for public and private coverage accessible through OHA and Cover Oregon;

(B) Health plan choices, criteria and how to enroll in public medical programs or Cover Oregon private insurance product choices.

(b) The application assister must make copies of the original eligibility verification documentation required to accompany the application, but not uploaded to the Cover Oregon portal.

(7) The site shall log into Cover Oregon portal to track applications with which they have assisted. If site uses a hard copy application, site will use reporting process provided by Authority.

(8) Providers, staff, contracted employees and volunteers are subject to all applicable provisions under General Rules OAR chapter 410, division 120.

(a) The application assister shall treat all information they obtain for public medical programs and Cover Oregon private insurance as confidential and privileged communications. The application assister shall not disclose such information without the written consent of the individual, his or her delegated authority, attorney, or responsible parent of a minor child or child’s guardian. Nothing prohibits the disclosure of information in summaries, statistical or other form, which does not identify particular individuals;

(b) The Authority and sites will share information as necessary to effectively serve public medical programs and Cover Oregon eligible or potentially eligible individuals;

(c) Personally identifiable health information about applicants and recipients will be subject to the transaction, security and privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the administrative rules there under. Sites will cooperate with the Authority in the adoption of policies and procedures for maintaining the privacy and security of records and for conducting transactions pursuant to HIPAA requirements.

(9) The Authority will be responsible for the following:

(a) The Authority will provide training to application assisters on public medical programs and Cover Oregon private insurance products, eligibility and enrollment, application procedures and documentation requirements. The Authority will set dates and times for these additional training classes as needed, following changes in policy or procedure;

(b) The Authority will make available public medical programs and Cover Oregon application forms online and in hard copy (in English, translated languages and alternative formats), health insurance coverage options, assister identification number instructions, reporting guidance and other necessary forms;

(c) The Authority and Cover Oregon will process all applications in accordance with Authority and Cover Oregon standards;

(d) The Authority and Cover Oregon will process completed applications, which have satisfactory verification information, within the time requirements set forth in Authority and Cover Oregon policy. In the event of a change in policy, the time for completion of processing shall be changed to the new time requirements.

(10) The Authority and Cover Oregon will provide all necessary forms and applications as referenced above at no cost to the site. There are no monetary provisions in this rule for any payment for the performance of work by the site, except for those costs provided under OAR 410-147-0400 and 410-146-0460. However, the parties acknowledge the exchange and receipt of other valuable considerations in the spirit of cooperation to the benefit of all by collaborating and authorizing the performance of the work. The Authority does not guarantee a particular volume of business under these rules.

(11) The provider may terminate enrollment at any time as outlined in OAR 410-120-1260(14).

Stat. Auth.: 413.042

Statutes Implemented: 414.041

410-120-0250 – PHP or Coordinated Care Organizations

(1) The Authority provides clients with health services, through contracts with a Prepaid Health Plan (PHP) or a Coordinated Care Organization (CCO).

(2) The PHP or CCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law, the PHP or CCO's contract with the Authority and the OHP administrative rules governing PHPs and CCOs (OAR 410 division 141).

(3) All PHP or CCOs are required to provide benefit coverage pursuant to OAR 410-120-1210 and 410-141-0480 through 410-141-0520, however, authorization criteria may vary between PHP or CCOs. It is the providers' responsibility to comply with the PHP or CCO's Prior Authorization requirements or other policies necessary for reimbursement from the PHP or CCO, before providing services to any OHP client enrolled in a PHP or CCO.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025, 414.065, 414.725 & 414.737

410-120-1140 – Verification of Eligibility and Coverage

(1) To ensure Division reimbursement of services, providers are responsible to verify the following before rendering services:

(a) Client eligibility: That the person is an eligible Oregon Health Plan (OHP) client on the date(s) services are rendered; and

(b) Benefit coverage: That the person is enrolled in an OHP benefit package that covers the services they plan to render. See OAR 410-120-1210 for services covered under each Division benefit package.

(2) Providers who do not verify eligibility and benefit coverage with the Division before serving a person shall assume full financial responsibility in serving that person.

(3) The following types of client identification (ID) only list the client's name, Oregon Medicaid ID number (prime number), and the date the ID was issued. They do not guarantee client eligibility or benefit coverage:

(a) The standard ID (called the Oregon Health ID, formerly the DHS Medical Care ID) printed on perforated paper the size of a business card;

(b) Replacement IDs (printed on regular printer paper in case of misplaced originals).

(4) When a person presents a standard or replacement ID, providers must verify client eligibility and benefit coverage through one of the following (For instructions see the Division General Rules Supplemental Information available on the web at www.dhs.state.or.us/policy/healthplan/guides/genrules/genrules-supp0912.pdf.):

(a) The Division's Medicaid Management Information System (MMIS) Provider Web portal;

(b) The Automated Voice Response (AVR) telephone system;

(c) Batch or real-time electronic data interchange (EDI) eligibility inquiry (270) and response (271) transactions;

(5) The client may also present one of the following Temporary Oregon Health IDs; both are full-page forms:

(a) DMAP form 1086: This document guarantees eligibility and benefit coverage for seven days from the beginning dates of coverage entered in Part 1 of the form. This temporary ID is issued only if the client needs immediate care but their eligibility and coverage information is not yet available for verification as described in part (4) of

this rule. Providers must honor the Temporary Oregon Health ID when presented within seven (7) days of the beginning date of coverage entered on the form;

(b) OHP 3263A: Approval Notice for Hospital Presumptive Eligibility for Medical Coverage: This ID is issued for those who are “presumed” eligible based on certain information and authorizes benefit coverage only on a temporary basis. The OHP 3263A informs the client of the exact date by which the Division must receive their full Medicaid application so that they may be evaluated for ongoing eligibility.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065, 414.025 & 414.047

410-120-1160 – Medical Assistance Benefits and Provider Rules

(1) Providers enrolled with and seeking reimbursement for services through the Division of Medical Assistance Programs (Division) are responsible for compliance with current federal and state laws and regulations governing Medicaid services and reimbursement, including familiarity with periodic law and rule changes. The Division's administrative rules are posted on the Oregon Health Authority (Authority) website for the Division and its medical assistance programs. It is the provider's responsibility to become familiar with and abide by these rules.

(2) The following services are covered to the extent included in the Division client's benefit package of health care services, when medically or dentally appropriate and within the limitations established by the Division and set forth in the Oregon Administrative Rules (OARs) for each category of Medical Services:

(a) Acupuncture services as described in the Medical-Surgical Services program provider rules (OAR chapter 410, division 130);

(b) Administrative examinations as described in the Administrative Examinations and Billing Services program provider rules (OAR chapter 410, division 150);

(c) Substance Use Disorder treatment services:

(A) The Division covers substance use disorder (SUD) inpatient treatment services for medically managed intensive inpatient detoxification when provided in an acute care hospital and when hospitalization is considered medically appropriate. The Division covers medically monitored detoxification and clinically managed detoxification provided in a free standing detoxification center or an appropriately licensed SUDs residential treatment facility when considered medically appropriate;

(B) The Division covers non-hospital SUD treatment and recovery services on a residential or outpatient basis. For information to access these services, contact the client's PHP or CCO if enrolled, the community mental health program (CMHP), an outpatient substance use disorder treatment provider, the residential treatment program, or the Addictions and Mental Health Division (AMH);

(C) The Division does not cover residential level of care provided in an inpatient hospital setting for substance use disorder treatment and recovery;

(d) Ambulatory surgical center services as described in the Medical-Surgical Services program provider rules (OAR 410, division 130);

(e) Anesthesia services as described in the Medical-Surgical Services program provider rules (OAR chapter 410, division 130);

(f) Audiology services as described in the Speech-Language Pathology, Audiology and Hearing Aid Services program provider rules (OAR chapter 410, division 129);

(g) Chiropractic services as described in the Medical-Surgical Services program provider rules (OAR chapter 410, division 130);

(h) Dental services as described in the Dental Services program provider rules (OAR chapter 410, division 123);

(i) Early and periodic screening, diagnosis, and treatment services (EPSDT) are covered for individuals under 21 years of age as set forth in the individual program provider rules. The Division may authorize services in excess of limitations established in the OARs when it is medically appropriate to treat a condition that is identified as the result of an EPSDT screening;

(j) Family planning services as described in the Medical-Surgical Services program provider rules (OAR chapter 410, division 130);

(k) Federally qualified health centers and rural health clinics as described in the Federally Qualified Health Centers and Rural Health Clinics program provider rules (OAR chapter 410, division 147);

(l) Home and community-based waiver services as described in the Authority and the Department's OARs of Child Welfare (CW), Self-Sufficiency Program (SSP), Addictions and Mental Health Division (AMH), and Aging and People with Disabilities Division (APD);

(m) Home enteral/parenteral nutrition and IV services as described in the Home Enteral/Parenteral Nutrition and IV Services program rules (OAR chapter 410, division 148) and related Durable Medical Equipment. Prosthetics, Orthotics and Supplies program rules (OAR chapter 410, division 122) and Pharmaceutical Services program rules (OAR chapter 410, division 121);

(n) Home health services as described in the Home Health Services program rules (OAR chapter 410, division 127);

(o) Hospice services as described in the Hospice Services program rules (OAR chapter 410, division 142);

(p) Indian health services or tribal facility as described in The Indian Health Care Improvement Act and its amendments (Public Law 102-573), and the Division's American Indian/Alaska Native program rules (OAR chapter 410, division 146);

(q) Inpatient hospital services as described in the Hospital Services program rules (OAR chapter 410, division 125);

(r) Laboratory services as described in the Hospital Services program rules (OAR chapter 410, division 125) and the Medical-Surgical Services program rules (OAR chapter 410, division 130);

(s) Licensed direct-entry midwife services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);

(t) Maternity case management as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);

(u) Medical equipment and supplies as described in the Hospital Services program, Medical-Surgical Services program, DMEPOS program, Home Health Services program, Home Enteral/Parenteral Nutrition and IV Services program, and other rules;

(v) When a client's benefit package includes mental health, the mental health services provided will be based on the Health Evidence Review Commission (HERC) Prioritized List of Health Services;

(w) Naturopathic services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);

(x) Nutritional counseling as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);

(y) Occupational therapy as described in the Physical and Occupational Therapy Services program rules (OAR chapter 410, division 131);

(z) Organ transplant services as described in the Transplant Services program rules (OAR chapter 410, division 124);

(aa) Outpatient hospital services including clinic services, emergency department services, physical and occupational therapy services, and any other outpatient hospital services provided by and in a hospital as described in the Hospital Services program rules (OAR chapter 410, division 125);

(bb) Physician, podiatrist, nurse practitioner and licensed physician assistant services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);

(cc) Physical therapy as described in the Physical and Occupational Therapy and the Hospital Services program rules (OAR chapter 410, division 131 and 125);

(dd) Post-hospital extended care benefit as described in OAR chapter 410, division 120 and 141 and Aging and People with Disabilities (APD) program rules;

(ee) Prescription drugs including home enteral and parenteral nutritional services and home intravenous services as described in the Pharmaceutical Services program (OAR chapter 410, division 121), the Home Enteral/Parenteral Nutrition and IV Services program (OAR chapter 410, division 148), and the Hospital Services program rules (OAR chapter 410, division 125);

(ff) Preventive services as described in the Medical-Surgical Services program (OAR chapter 410, division 130), the Dental Services program rules (OAR chapter 410, division 123), and prevention guidelines associated with the Health Evidence Review Commission's Prioritized List of Health Services (OAR 410-141-0520);

(gg) Private duty nursing as described in the Private Duty Nursing Services program rules (OAR chapter 410, division 132);

(hh) Radiology and imaging services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130), the Hospital Services program rules (OAR chapter 410, division 125), and Dental Services program rules (OAR chapter 410, division 123);

(ii) Rural health clinic services as described in the Federally Qualified Health Center and Rural Health Clinic Program rules (OAR chapter 410, division 147);

(jj) School-based health services as described in the School-Based Health Services Program rules (OAR chapter 410, division 133);

(kk) Speech and language therapy as described in the Speech-Language Pathology, Audiology and Hearing Aid Services program rules (OAR chapter 410, division 129) and Hospital Services program rules (OAR chapter 410, division 125);

(LL) Transportation necessary to access a covered medical service or item as described in the Medical Transportation program rules (OAR chapter 410, division 136);

(mm) Vision services as described in the Visual Services program rules (OAR chapter 410, division 140).

(3) Other Authority or Department, divisions, units, or offices, including Vocational Rehabilitation, AMH, and APD may offer services to Medicaid eligible clients, that are not reimbursed by or available through the Division of Medical Assistance Programs.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-120-1180 – Medical Assistance Benefits: Out-of-State Services

(1) Out-of-state Providers must enroll with the Division as described in OARs 407-120-0320 and 410-120-1260, Provider Enrollment. Out-of-state Providers must provide services and bill in compliance with all of these Rules and the OARs for the appropriate type of service(s) provided.

(2) Payment rates for out-of-state providers are established in the individual provider rules, through contracts or service agreements and in accordance with OAR chapter 943 division 120 and OAR 410-120-1340, Payment.

(3) For enrolled non-contiguous, out-of-state providers, the Division reimburses for covered services under any of the following conditions:

(a) For clients enrolled in a CCO or PHP:

(A) The service was authorized by a CCO or PHP and payment to the out-of-State provider is the responsibility of the CCO or PHP;

(B) If a client has coverage through a CCO or PHP, the request for non-emergency services must be referred to the CCO or PHP. Payment for these services is the responsibility of the CCO or PHP;

(C) The service or item is not available in the State of Oregon or provision of the service or item by an out-of-State provider is cost effective, as determined by the CCO or PHP.

(b) For clients not enrolled in a CCO or PHP:

(A) The service to a Division client was emergent; or

(B) A delay in the provision of services until the client is able to return to Oregon could reasonably be expected to result in prolonged impairment, or in increased risk that treatment will become more complex or hazardous, or in substantially increased risk of the development of chronic illness;

(C) The Division authorized payment for the service in advance of the provision of services or was otherwise authorized in accordance with Payment Authorization requirements in the individual provider rules or in the General Rules;

(D) The service is being billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage.

(4) The Division may give prior authorization (PA) for non-emergency out-of-state services provided by a non-contiguous enrolled Provider, under the following conditions:

(a) The service is being billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage, or

(b) The Division covers the service or item under the specific client's benefit package; and

(c) The service or item is not available in the State of Oregon or provision of the service or item by an out-of-state provider is cost effective, as determined by the Division; and

(d) The service or item is deemed medically appropriate and is recommended by a referring Oregon physician;

(5) Laboratory analysis of specimens sent to out-of-state independent or hospital-based Laboratories is a covered service and does not require PA. The Laboratory must meet the same certification requirements as Oregon Laboratories and must bill in accordance with Division rules.

(6) The Division makes no reimbursement for services provided to a Client outside the territorial limits of the United States. For purposes of this provision the “United States” includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

(7) The Division will reimburse, within limits described in these General rules and in individual provider rules, all services provided by enrolled providers to children:

(a) Who the Authority has placed in foster care;

(b) Who the Department has placed in a subsidized adoption outside the State of Oregon; or

(c) Who are in the custody of the Department and traveling with the consent of the Department.

(8) The Division does not require authorization of non-emergency services for the children covered by (7), except as specified in the individual provider rules.

(9) Payment rates for out-of-state providers are established in the individual provider rules, through contracts or service agreements and in accordance with OAR 407-120-0350 and 410-120-1340, Payment.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065 & 414.025

410-120-1190 – Medically Needy Benefit Program

The Medically Needy Program is eliminated effective February 1, 2003. Although references to this benefit exist elsewhere in rule, the program currently is not funded and is not offered as a benefit.

Stat. Auth.: ORS 413.042,

Stats. Implemented: ORS 414.025, 414.065

410-120-1195 – SB 5548 Population

Effective Effective for services rendered on or after January 1, 2004.

(1) Certain individuals previously participating in the OSIP-MN Medically Needy Program as of January 31, 2003, and who are identified by the Authority with specific health-related conditions as outlined in the Joint Ways and Means budget note accompanying Senate Bill 5548 (2003) shall be referred to as SB 5548 clients.

(2) SB 5548 clients are eligible for a State-funded, limited, prescription drug benefit for covered drugs described in subsection (3) of this rule.

(3) Eligibility for and access to covered drugs for SB 5548 clients:

(a) SB 5548 clients must have been participating in the former OSIP-MN Medically Needy Program as of January 31, 2003, and as of that date had a medical diagnosis of HIV or organ transplant status;

(b) SB 5548 clients receiving anti-retroviral and other prescriptions necessary for the direct support of HIV symptoms:

(A) Must agree to participate in the Authority's CareAssist Program in order to obtain access to this limited prescription drug benefit; and

(B) Prescriptions are limited to those listed on the CareAssist Formulary which can be found at www.dhs.state.or.us/publichealth/ hiv/careassist/frmlry.cfm;

(c) SB 5548 clients receiving prescriptions necessary for the direct support of organ transplants are limited:

(A) Drug coverage includes any Medicaid reimbursable immunosuppressive, anti-infective or other prescriptions necessary for the direct support of organ transplants;

(B) Some drug classes are subject to restrictions or limitations based upon the Practitioner-Managed Prescription Drug Plan, OAR 410-121-0030.

(4) Reimbursement for covered prescription drugs is limited by the terms and conditions described in this rule. This limited drug benefit provides State-funded reimbursement to pharmacies choosing to participate according to the terms and conditions of this rule:

(a) The Authority will send SB 5548 clients a letter from the Authority, instead of a Medical Care Identification, which will document their eligibility for this limited drug benefit;

(b) Retail pharmacies choosing to participate will be reimbursed for covered prescription drugs for the direct support of organ transplants described in subsection (3)(c) of this rule based upon Oregon Medicaid reimbursement levels as specified in the Division's Pharmaceutical Services Program administrative rules 410-121-0155 and 410-121-0160.

(c) The Authority pharmacy benefits manager, will process retail pharmacy drug benefit reimbursement claims for SB 5548 clients;

(d) Mail order reimbursement will be subject to the Authority contract rates;

(e) Prescription drugs through the CareAssist program will be subject to the Authority contract rates;

(f) Reimbursement for this limited drug benefit is not subject to the following rules:

(A) 410-120-1230, Client Copayments;

(B) 410-121-0300, Federal Upper Limit (FUL) for prescription drugs.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

410-120-1200 – Excluded Services and Limitations

(1) Certain services or items are not covered under any program or for any group of eligible clients. Service limitations are subject to the Health Evidenced Review Commission (HERC) Prioritized List of Health Services as referenced in 410-141-0520 and the individual program chapter 410 OARs. If the client accepts financial responsibility for a non-covered service, payment is a matter between the provider and the client subject to the requirements of OAR 410-120-1280.

(2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

(a) Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

(b) Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

(c) Not properly prescribed as required by law or administrative rule by a licensed practitioner practicing within his or her scope of practice or licensure;

(d) For routine checkups or examinations for individuals age 21 or older in connection with participation, enrollment, or attendance in a program or activity not related to the improvement of health and rehabilitation of the client. Examples include exams for employment or insurance purposes;

(e) Provided by friends or relatives of eligible clients or members of his or her household, except when the friend, relative or household member:

(A) Is a health professional acting in a professional capacity; or

(B) Is directly employed by the client under the Department of Human Services (Department) Aging and People with Disabilities division (APD) Home and Community Based Services or the APD administrative rules, OAR 411-034-0000 through 411-034-0090, governing Personal Care Services covered by the State Plan; or

(C) Is directly employed by the client under the Department Child Welfare administrative rules, OAR 413-090-0100 through 413-090-0220, for services to children in the care and custody of the Department who have special needs inconsistent with their ages. A family member of a minor client (under the age of

18) must not be legally responsible for the client in order to be a provider of personal care services;

(f) For services or items provided to a client who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, except such services as designated by federal statute or regulation as permissible for coverage under the Division's administrative rules (i.e., inpatient hospitalizations);

(g) Needed for purchase, repair, or replacement of materials or equipment caused by adverse actions of adult clients age 21 and over to personally owned goods or equipment or to items or equipment that the Division rented or purchased;

(h) Related to a non-covered service; some exceptions are identified in the individual provider rules. If the Division determines the provision of a service related to a non-covered service is cost effective, the related medical service may, at the discretion of the Division and with Division prior authorization (PA), be covered;

(i) Considered experimental or investigational, including clinical trials and demonstration projects, or that deviates from acceptable and customary standards of medical practice or for which there is insufficient outcome data to indicate efficacy;

(j) Identified in the appropriate program rules including the Division's Hospital Services program administrative rules, Revenue Codes Section, as non- covered services.

(k) Requested by or for a client whom the Division has determined to be non-compliant with treatment and who is unlikely to benefit from additional related, identical, or similar services;

(l) For copying or preparing records or documents, except those Administrative Medical Reports requested by the branch offices or the Division for casework planning or eligibility determinations;

(m) Whose primary intent is to improve appearances, exceptions subject to the HERC coverage and guidelines;

(n) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

(o) For the purpose of establishing or reestablishing fertility or pregnancy;

(p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

(q) The collection, processing, and storage of autologous blood or blood from selected donors unless a physician certifies that the use of autologous blood or blood from a selected donor is medically appropriate and surgery is scheduled;

(r) Educational or training classes that are not intended to improve a medical condition;

(s) Outpatient social services except maternity case management services and other social services described as covered in the individual provider rules;

(t) Post-mortem exams or burial costs;

(u) Radial keratotomies

(v) Recreational therapy;

(w) Telephone calls except for:

(A) Tobacco cessation counseling as described in OAR 410-130-0190;

(B) Maternity case management as described in OAR 410-130-0595;

(C) Telemedicine as described in OAR 410-130-0610; and

(D) Services specifically identified as allowable for telephonic delivery when appropriate in the mental health and substance use disorder procedure code and reimbursement rates published by the Addiction and Mental Health division;

(x) Services that have no standard code set as established according to 45 CFR 162.1000 to 162.1011, unless the Division has assigned a procedure code to a service authorized in rule;

(y) Whole blood (Whole blood is available at no cost from the Red Cross.); The processing, storage, and costs of administering whole blood are covered;

(z) Immunizations prescribed for foreign travel;

(aa)Services that are requested or ordered but not provided to the client, unless specified otherwise in individual program rules;

(bb) Missed appointments, an appointment that the client fails to keep. Refer to 410-120-1280;

(cc) Transportation to meet a client's personal choice of a provider;

(dd) Alcoholics Anonymous (AA) and other self-help programs;

(ee) Medicare Part D covered prescription drugs or classes of drugs and any cost sharing for those drugs for Medicare-Medicaid Fully Dual Eligible clients, even if the Fully Dual Eligible client is not enrolled in a Medicare Part D plan. See OAR 410-120-1210 for benefit package;

(ff) Services provided outside of the United States. Refer to OAR 410-120-1180.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065, 414.025

410-120-1210 – Medical Assistance Benefit Packages and Delivery System

(1) The services clients are eligible to receive are based on their benefit package. Not all packages receive the same benefits.

(2) The Division of Medical Assistance Programs (Division) benefit package description, codes, eligibility criteria, coverage, limitations and exclusions are identified in these rules.

(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in any Division chapter 410 OARs.

(4) Benefit package descriptions:

(a) Oregon Health Plan (OHP) Plus:

(A) Benefit package identifier: BMH;

(B) Eligibility criteria: As defined in federal regulations and in the 1115 OHP waiver demonstration, a client is categorically eligible for medical assistance if he or she is eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria.

(C) Coverage includes:

(i) Services above the funding line on the Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List), (OAR 410-141-0480 through 410-141-0520);

(ii) Ancillary services, (OAR 410-141-0480);

(iii) Substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;

(iv) Mental health services based on the Prioritized List to be provided through Community Mental Health Programs or their subcontractors;

(v) Hospice;

(vi) Post-hospital extended care benefit, up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043), or by the Fully Capitated Health Plan (FCHP) for clients enrolled in an FCHP;

(vii) Cost sharing (e.g., copayments) may apply to some covered services.

(D) Limitations: The following services have limited coverage for non-pregnant adults age 21 and older. (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410, division 123);

(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140).

(b) OHP with Limited Drug:

(A) Benefit Package identifier: BMM, BMD;

(B) Eligibility criteria: Eligible clients are eligible for Medicare and Medicaid benefits;

(C) Coverage includes:

(i) Services covered by Medicare and OHP Plus as described in this rule;

(D) Limitations:

(i)The same as OHP Plus, as described in this rule;

(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to:

(I) Over-the-counter (OTC) drugs;

(II) Barbiturates (except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications).

(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug.

(F) Payment for services is limited to the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible;

(G) Cost sharing may apply to some covered services; however cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package;

(c) Qualified Medicare Beneficiary (QMB)-Only:

(A) Benefit Package identifier code MED;

(B) Eligibility criteria: Eligible clients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage;

(C) Coverage: Is limited to the co-insurance or deductible for the Medicare service. Payment is based on the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible, but no more than the Medicare allowable;

(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare.

(d) Citizen/Alien-Waived Emergency Medical (CAWEM):

(A) Benefit Package identifier CWM;

(B) Eligibility criteria: Eligible clients are non-qualified aliens that are not eligible for other Medicaid programs pursuant to Oregon Administrative Rules (OAR) 461-135-1070;

(C) Coverage is limited to:

(i) Emergency medical services as defined by 42 CFR 440.255. Sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part (the “prudent layperson standard” does not apply to the CAWEM emergency definition);

(ii) Labor and Delivery.

(D) Exclusions: The following services are not covered even if they are sought as emergency services:

(i) Prenatal or postpartum care;

(ii) Sterilization;

(iii) Family Planning;

(iv) Preventive care;

(v) Organ transplants and transplant-related services;

(vi) Chemotherapy;

(vii) Hospice;

(viii) Home health;

(ix) Private duty nursing;

(x) Dialysis;

(xi) Dental services provided outside of an emergency department hospital setting;

(xii) Outpatient drugs or over-the-counter products;

(xiii) Non-emergency medical transportation;

(xiv) Therapy services;

(xv) Durable medical equipment and medical supplies;

(xvi) Rehabilitation services.

(e) CAWEM Plus:

(A) Benefit Package identifier code CWX;

(B) Eligibility criteria: As defined in federal regulations and in the Children's Health Insurance Program (CHIP) state plan eligible clients are CAWEM pregnant women not eligible for Medicaid at or below 185 percent of the Federal Poverty Level (FPL);

(C) Coverage includes:

(i) Services covered by OHP Plus as described above;

(D) Exclusions: The following services are not covered for this program:

(i) Postpartum care (except when provided and billed as part of a global obstetric package code that includes the delivery procedure);

(ii) Sterilization;

(iii) Abortion;

(iv) Death with dignity services;

(v) Hospice.

(E) The day after pregnancy ends, eligibility for medical services shall be based on eligibility categories established in OAR chapter 461.

(5) Division clients are enrolled for covered health services to be delivered through one of the following means:

(a) Coordinated Care Organization (CCO):

(A) These clients are enrolled in a CCO that provides integrated and coordinated health care;

(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, substance use disorder treatment and recovery, mental health services or dental care.

(b) Prepaid Health Plan (PHP):

(A) These clients are enrolled in a PHP for their medical, dental or mental health care;

(B) Most non-emergency services are obtained from the PHP or require a referral from the PHP that is responsible for the provision and reimbursement for the medical, dental or mental health service;

(c) Physician Care Organization (PCO):

(A) These clients are enrolled in a PCO for their medical care;

(B) Inpatient hospital services are not the responsibility of the PCO and are governed by the Division's Hospital Services Program rule (OAR chapter 410, Division 125).

(d) Fee-for-service (FFS):

(A) These clients are not enrolled in a CCO, PHP, PCO;

(B) Subject to limitations and restrictions in the Division's individual program rules, the client can receive health care from any Division-enrolled provider that

accepts FFS clients. The provider shall bill the Division directly for any covered service and shall receive a fee for the service provided.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.329, 414.706, 414.707, 414.708, 414.710

410-120-1230 – Client Co-payment

(1) Oregon Health Plan (OHP) Plus clients shall be responsible for paying a co-payment for some services. This co-payment shall be paid directly to the provider. A co-payment applies regardless of location of services rendered, i.e., provider's office or client's residence.

(2) The following services are exempt from co-payment:

(a) Emergency medical services as defined in OAR 410-120-0000;

(b) Family planning services and supplies;

(c) Prescription drug products for nicotine replacement therapy (NRT);

(d) Prescription drugs ordered through the Division of Medical Assistance Programs' (Division's) Mail Order (a.k.a., Home-Delivery) Pharmacy program;

(e) Services to treat "health care-acquired conditions" (HCAC) and "other provider preventable conditions" (OPPC) services as defined in OAR 410-125-0450.

(3) The following clients are exempt from co-payments:

(a) Pregnant women;

(b) Children under age 19;

(c) Young adults in substitute care and in the former Foster Care Youth Medical program;

(d) Clients receiving services under the Medicaid-funded home and community-based services program;

(e) Inpatients in a hospital, nursing facility, or Intermediate Care Facility for Intellectually or Developmentally Disabled (ICF/IDD);

(f) American Indian/Alaska Native (AI/AN) clients who are members of a federally recognized Indian tribe or receive services through Indian Health Services (IHS), a tribal organization, or services provided at an Urban Tribal Health Clinic as provided under Public Law 93-638;

(g) Individuals receiving hospice care;

(h) Individuals eligible for the Breast and Cervical Cancer program.

(4) Co-payment for services is due and payable at the time the service is provided unless exempted in sections (2) and (3) above. Services to a client may not be denied solely because of an inability to pay an applicable co-payment. This does not relieve the client of the responsibility to pay the applicable co-payment, nor does it prevent the provider from attempting to collect any applicable co-payments from the client. The co-payment is a legal debt and is due and payable to the provider of service.

(5) Except for prescription drugs, one co-payment is assessed per provider/per visit/per day unless otherwise specified in other Division's program administrative rules.

(6) Fee-for-service co-payment requirements:

(a) The provider may not deduct the co-payment amount from the usual and customary billed amount submitted on the claim. Except as provided in section (2) and (3) of this rule, the Division shall deduct the co-payment from the amount the Division pays to the provider (whether or not the provider collects the co-payment from the client);

(b) If the Division's payment is less than the required co-payment, then the co-payment amount is equal to the Division's lesser required payment, unless the client or services are exempt according to exclusions listed in section (2) and (3) above. The client's co-payment shall constitute payment-in-full;

(c) Unless specified otherwise in individual program rules and to the extent permitted under 42 CFR 1001.951–1001.952, the Division does not require providers to bill or collect a co-payment from the Medicaid client. The provider may choose not to bill or collect a co-payment from a Medicaid client; however, the Division shall still deduct the co-payment amount from the Medicaid reimbursement made to the provider.

(7) CCO, PHP, or PCO co-payment requirements:

(a) Unless specified otherwise in individual program rules and to the extent permitted under 42 CFR 447.58 and 447.60, the Division does not require CCOs, PHPs, or PCOs to bill or collect a co-payment from the Medicaid client. The CCO, PHP, or PCO may choose not to bill or collect a co-payment from a Medicaid client; however, the Division shall still deduct the co-payment amount from the Medicaid reimbursement made to the CCO, PHP, or PCO;

(b) When a CCO, PHP, or PCO is operating within the scope of the safe harbor regulation outlined in 42 CFR 1001.952(l), a CCO, PHP, or PCO may elect to assess a co-payment on some of the services outlined in Table 120-1230-1 but not all. The CCO, PHP, or PCO must assure they are working within the provisions of 42 CFR 1003.102(b) (13). [Table not included. See ED. NOTE.]

(8) Services that require co-payments are listed in Table 120-1230-1. [Table not included. See ED. NOTE.]

(9) Table 120-1230-1. [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are not included in rule text. The table is available by clicking here.]

Stat. Auth.: ORS 413.042

Stat. Implemented: ORS 414.025, 414.065

Table 120-1230-1

OHP Benefit Package Client Co-payment Requirements (Benefit Identifier)	OHP Plus (BMH,BMD, BMM)
Acupuncture services	$3
Ambulance services (emergency)	$0
Ambulatory Surgical Center	$3
Audiology services • Hearing Aids	$3 $0
Chemical Dependency services • Outpatient services • Medication dosing/dispensing, case management • Inpatient hospital detoxification	 $3 $0 $0
Chiropractic services	$3
Dental services • Diagnostic –(D0100-D0999)oral examinations used to determine changes in the patient's health or dental status, including x-rays, laboratory services and tests associated with making a diagnosis and/or treatment. • Preventive services (D1000-D1999) routine cleanings fluoride, sealants • Restorative treatment or other dental services (D2000-D9999)	 $0 $0 $3
DME and supplies	$0
Home visits for • Home health • Private duty nursing • Enteral/Parenteral	 $3 $3 $3
Hospital • Inpatient care • Outpatient surgery • Emergency room services • Outpatient, other • Non-emergent visit performed in the ER	 $0 $3 $0 $3 $3
Laboratory test	$0
Mental Health services • Inpatient hospitalization- includes ancillary, facility and professional fees (DRG 424-432); • Initial assessment/evaluation by psychiatrist or psychiatric mental health nurse practitioners (90801); • Outpatient hospital- Electroconvulsive (ECT) treatment (Revenue code 901) including facility, professional fees (90870-90871) and anesthesiology fees (00104); • Medication Management by psychiatrist or psychiatric mental health nurse practitioner (90862);	 $3 $3 $3 $0

OHP Benefit Package Client Co-payment Requirements (Benefit Identifier)	OHP Plus (BMH,BMD, BMM)
• Consultation between psychiatrist/psychiatric mental health nurse practitioner and primary care physician (90887)	$0
Naturopathic services	$3
Podiatry services	$3
Prescription drugs • Non-preferred PDL or generics in non-PDL classes costing >$10 • Preferred PDL generic or generics in non-PDL classes costing <$10 • Preferred PDL brand • All other brands Refer to OAR 410-121-0030 for PDL list PDL list is not applicable to those enrolled in MCO, contact the MCO for details.	$1 $0 $0 $3
Professional visits for • Primary care, including urgent care by a Physician, Physician Assistant, Certified Nurse Practitioner • Specialty care • Office medical procedures • Surgical procedures • PT/OT/Speech	$3 $3 $0 $0 $3
Radiology • Diagnostic procedures • Treatments	$0 $0
Vision services • Exams- for medical purposes or solely for glasses • Frames, contracts, corrective devices	$3 $0

410-120-1260 – Provider Enrollment

(1) This rule applies to providers enrolled with or seeking to enroll with the Division of Medical Assistance Programs (Division).

(2) Providers signing the Provider Enrollment Agreement constitute agreement to comply with all applicable Division provider rules and federal and state laws and regulations.

(3) Providers enrolled by the Division include:

(a) A non-payable provider, meaning a provider who is issued a provider number for purposes of data collection or non-claims-use such as, but not limited to:

(A) Ordering or referring providers whose only relationship with the Division is to order, refer, or prescribe services for Division clients;

(B) A billing agent or billing service submitting claims or providing other business services on behalf of a provider but not receiving payment in the name of or on behalf of the provider;

(C) An encounter only provider: A provider contracted with a PHP or CCO.

(b) A payable provider, meaning a provider who is issued a provider number for the purpose of submitting health care claims for reimbursement from the Division. A payable provider may be:

(A) The rendering provider;

(B) An individual, agent, business, corporation, clinic, group, institution, or other entity that, in connection with the submission of claims, receives or directs the payment on behalf of a rendering provider;

(4) When an entity is receiving or directing payment on behalf of the rendering provider, the billing provider must:

(a) Meet one of the following standards as applicable:

(A) Have a relationship with the rendering provider described in 42 CFR 447.10(g) and have the authority to submit the rendering provider enrollment application and supporting documentation on behalf of the rendering provider;

(B) Is a contracted billing agent or billing service that has enrolled with the Division to provide services in connection with the submission of claims and to receive or direct payment in the name of the rendering provider pursuant to 42 CFR 447.10(f).

(b) Maintain and make available to the Division upon request records indicating the billing provider's relationship with the rendering provider. This includes:

(A) Identify all rendering providers for whom they bill or receive or direct payments at the time of enrollment;

(B) Notify the Division within 30 days of a change to the rendering provider’s name, date of birth, address, Division provider numbers, NPIs, Social Security Number (SSN), or the Employer Identification Number (EIN).

(c) Prior to submission of any claims or receipt or direction of any payment from the Division, obtain signed confirmation from the rendering provider that the billing entity or provider has been authorized by the rendering provider to submit claims or receive or direct payment on behalf of the rendering provider. This authorization, and any limitations or termination of such authorization, must be maintained in the provider's files for at least five years following the submission of claims or receipt or direction of funds from the Division.

(5) In order to facilitate timely claims processing and claims payment consistent with applicable privacy and security requirements for providers:

(a)The Division requires non-payable and payable providers to be enrolled consistent with the provider enrollment process described in this rule;

(b) If the rendering provider uses electronic media to conduct transactions with the Division or authorizes a non-payable provider, e.g. billing service or billing agent, to conduct such electronic transactions, the rendering provider must comply with the Authority Electronic Data Interchange (EDI) rules, OAR 943-120-0100 through 943-120-0200. Enrollment as a payable or non-payable provider is a necessary requirement for submitting electronic claims, but the provider must also register as an EDI trading partner and identify the EDI submitter in order to submit electronic claims.

(6) To be enrolled and able to bill as a provider, an individual or organization must:

(a) Meet applicable licensing and regulatory requirements set forth by federal and state statutes, regulations, and rules;

(b) Comply with all Oregon statutes and regulations for provision of Medicaid and CHIP services;

(c) If providing services within the State of Oregon, have a valid Oregon business license if such a license is a requirement of the state, federal, county, or city government to operate a business or to provide services.

(7) An Indian Health Service facility meeting enrollment requirements will be accepted on the same basis as any other qualified provider. However, when state licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure.

(8) An individual or organization that is currently subject to sanction by the Division, another state's Medicaid program, or the federal government is not eligible for enrollment (see OAR 410-120-1400, 943-120-0360, Provider Sanctions).

(9) Required information: All providers must meet the following requirements before the Division can issue or renew a provider number and must provide documentation at any time upon written request by the Division:

(a) Disclosure requirements: The provider must disclose to the Division:

(A) The identity of any person employed by the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or CHIP program in the last ten years;

(B) If the provider is an entity other than an individual practitioner or group of practitioners, disclose the following:

(i) The name, date of birth, address, and tax identification number of each person with an ownership or control interest in the provider or in any subcontractor in which the provider has a direct or indirect ownership interest of 5 percent or more. When disclosing tax identification numbers:

(I) For corporations, use the federal Tax Identification Number;

(II) For individuals in a solo practice or billing as an individual practitioner, use the Social Security Number (SSN);

(III) All other providers use the Employer Identification Number (EIN);

(IV) The SSN or EIN of the rendering provider cannot be the same as the Tax Identification Number of the billing provider;

(V) Pursuant to 42 CFR 433.37, including federal tax laws at 26 USC 6041, SSN's and EIN's provided are used for the administration of federal, state, and local tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities;

(ii) Whether any of the persons so named:

(I) Is related to another as spouse, parent, child, sibling, or other family members by marriage or otherwise; and

(II) Has an ownership or control interest in any other entity.

(C) A provider must submit within 35 days of the date of a request full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and any significant business transactions between the provider and any wholly owned supplier or between the provider and any subcontractor during the five-year period ending on the date of the request;

(b) Provider screening and enrollment requirements: The provider must submit the following information to the Division:

(A) For non-payable providers, a complete Non-Paid Provider Enrollment Request;

(B) For payable providers, a complete Provider Enrollment Request, Provider Enrollment Attachment, Disclosure Statement, and Provider Enrollment Agreement;

(C) Application fee if required under 42 CFR 455.460;

(D) Consent to criminal background check when required;

(E) To fulfill federal provider screening requirements pursuant to 42 CFR 455.436 and upon request, the name, date of birth, address, Division provider numbers, NPIs, and Social Security Number (SSN) of any provider who is enrolled or seeking enrollment with the Division.

(c) Verification of licensing or certification: Loss of the appropriate licensure or certification will result in immediate disenrollment of the provider and recovery of payments made subsequent to the loss of licensure or certification;

(d) Required updates: Enrolled providers must notify the Division in writing of material changes in any status or condition that relates to their qualifications or eligibility to provide medical assistance services including, but not limited to, those listed in this subsection:

(A) Failure to notify the Division of a change of Federal Tax Identification Number for entities or a Social Security Number or Employer Identification Number for individual rendering providers may result in the imposition of a $50 fine:

(i) If the Division notifies a provider about an error in their Federal Tax Identification, including Social Security Numbers or Employer Identification Numbers for individual rendering providers, the provider must supply the appropriate valid Federal Tax Identification Number within 30 calendar days of the date of the Division's notice.

(ii) Failure to comply with this requirement may result in the Division imposing a fine of $50 for each such notice. Federal Tax Identification requirements described in this rule refer to any such requirements established by the Internal Revenue Service;

(B) Changes in business affiliation, ownership, NPI and Federal Tax Identification Number, ownership and control information, or criminal convictions may require the submission of a provider enrollment form, provider enrollment agreement, provider certification, or other related documentation.

(C) In the event of bankruptcy proceedings, the provider shall immediately notify the Division administrator in writing;

(D) Claims submitted by or payments made to providers who have not furnished the notification required by this rule or to a provider that has failed to submit a new application as required by the Division under this rule may be denied or recovered.

(10) Rendering providers may be enrolled retroactive to the date services were provided to a Division client only if:

(a) The provider was appropriately licensed, certified, and otherwise met all Division requirements for providers at the time services were provided;

(b) Services were provided fewer than 12 months prior to the date the application for provider status was received by the Division as evidenced by the first date stamped on the paper claim submitted with the application materials for those services, either manually or electronically;

(11) The Division reserves the right to retroactively enroll the provider prior to the 12-month period based upon extenuating circumstances outside the control of the provider, consistent with federal Medicaid regulations, and with approval of the Division's Provider Enrollment Unit Manager.

(12) There are two types of provider numbers:

(a) Oregon Medicaid provider number: The Division issues provider numbers to establish an individual or organization's enrollment as an Oregon Medicaid provider.

(A) This number designates specific categories of services covered by the Division Provider Enrollment Attachment. For example, a pharmacy provider number applies to pharmacy services but not to durable medical equipment, which requires a separate provider application attachment and establishes a separate Oregon Medicaid provider number;

(B) For providers not subject to NPI requirements, this number is the provider identifier for billing the Division;

(b) National Provider Identifier (NPI) and taxonomy: The Division requires compliance with NPI requirements in 45 CFR Part 162. For providers subject to NPI requirements:

(A) The NPI and taxonomy codes are the provider identifier for billing the Division;

(B) Currently enrolled providers that obtain a new NPI are required to update their records with the Division's Provider Enrollment Unit;

(C) Provider applicants must obtain an NPI and include it in their provider enrollment request to the Division.

(13) Enrollment of out-of-state providers: Providers of services outside the State of Oregon will be enrolled as a provider if they comply with the requirements in OAR 410-120-1260 and under the following conditions:

(a) The provider is appropriately licensed or certified and meets standards for participation in the Medicaid program. Disenrollment or sanction from other states' Medicaid program or exclusion from any other federal or state health care program is a basis for disenrollment, termination, or suspension from participation as a provider in Oregon's medical assistance programs;

(b) Noncontiguous out-of-state pharmacy providers must be licensed by the Oregon Board of Pharmacy to provide pharmacy services in Oregon. In instances where clients are out of the state due to travel or other circumstances that prevent them from using a pharmacy licensed in Oregon and prescriptions need to be filled, the pharmacy is required to be licensed in the state they are doing business where the client filled the prescription and must be enrolled with the Division in order to submit claims. Out-of-state Internet or mail order, except the Division's mail order vendor, prescriptions are not eligible for reimbursement;

(c) The provider bills only for services provided within the provider's scope of licensure or certification;

(d) For noncontiguous out-of-state providers, the services provided must be authorized in the manner required under these rules for out-of-state services (OAR 410-120-1180) or other applicable Authority rules:

(A) The services provided are for a specific Oregon Medicaid client who is temporarily outside Oregon or the contiguous area of Oregon; or

(B) Services provided are for foster care or subsidized adoption children placed out of state; or

(C) The provider is seeking Medicare deductible or coinsurance coverage for Oregon Qualified Medicare Beneficiaries (QMB) clients;

(D) The services for which the provider bills are covered services under the Oregon Health Plan (OHP).

(e) Facilities including but not restricted to hospitals, rehabilitative facilities, institutions for care of individuals with mental retardation, psychiatric hospitals, and residential care facilities will be enrolled as providers only if the facility is enrolled as a Medicaid provider in the state in which the facility is located or is licensed as a facility provider of services by the State of Oregon;

(f) Out-of-state providers may provide contracted services per OAR 410-120-1880.

(g) Out-of-state billing providers may need to register with the Secretary of State and the Department of Revenue to transact business in Oregon pursuant to 943-120-0320(15)(f).

(14) Absentee Physicians: When a substitute physician is retained to take over another physician's professional practice while he or she is absent or unavailable, the following shall apply:

(a) The Division recognizes that absentee physicians may retain substitute physicians as a locum tenens or as part of a reciprocal billing arrangement. For purposes of this rule:

(A) A “locum tenens” means a substitute physician retained to take over another physician's professional practice while he or she is absent (i.e., absentee physician) for reasons such as illness, vacation, continuing medical education, pregnancy, etc.;

(B) A locum tenens cannot be retained to take over a deceased physician’s professional practice without becoming enrolled with the Division;

(C) A “reciprocal billing arrangement” means a substitute physician retained on an occasional basis;

(b) Substitute physicians are not required to enroll with the Division; however, the Division may enroll such providers at the discretion of the Division's provider enrollment manager if the provider submits all information required for provider enrollment as described in this rule;

(c) In no instance may an enrolled absentee physician utilize a substitute physician who is, at that time, excluded from participation in or under sanction by Medicaid or federally funded or federally assisted health programs;

(d) The absentee physician must be an enrolled Division provider and must bill with their individual Division assigned provider number and receive payment for covered services provided by the substitute physician:

(A) Services provided by the locum tenens must be billed with a modifier Q6;

(B) Services provided in a reciprocal billing arrangement by the substitute physician must be billed with a modifier Q5;

(C) In entering the Q5 or Q6 modifier, the absentee physician is certifying that the services are provided by a substitute physician identified in a record of the absentee physician that is available for inspection and are services for which the absentee physician is authorized to submit a claim;

(D) A physician or other person who falsely certifies that the requirements of this section are met may be subject to possible civil and criminal penalties for fraud, and the enrolled provider's right to receive payment or to submit claims may be revoked.

(e) These requirements do not apply to substitute arrangements among physicians in the same medical practice when claims are submitted in the name of the practice or group name.

(f) Nothing in this rule prohibits physicians sharing call responsibilities from opting out of the substitute provider arrangement described in this rule and submitting their own claims for services provided, as long as all such physicians are themselves enrolled rendering providers and as long as duplicate claims for services are not submitted.

(15) Provider termination:

(a) The provider may terminate enrollment at any time. The request must be in writing and signed by the provider. The notice shall specify the Division assigned provider number to be terminated and the effective date of termination. Termination of the provider enrollment does not terminate any obligations of the provider for dates of services during which the enrollment was in effect;

(b) The Division may terminate or suspend providers when a provider fails to meet one or more of the requirements governing a provider's participation in Oregon's medical assistance programs such as, but not limited to:

(A) Breaches of provider agreement;

(B) Failure to submit timely and accurate information as requested by the Division;

(C) Failure to submit fingerprints in a form determined by the Division within 30 days of request;

(D) Failure to permit access to provider locations for site visits;

(E) Failure to comply with federal or state statutes and regulations or policies of the Division that are applicable to the provider;

(F) No claims have been submitted in an 18-month period. The provider must reapply for enrollment;

(G) Any person who has an ownership or control interest in the provider or who is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid CHIP, or the Title XX services program in the last 10 years;

(H) Failure to fully and accurately make any disclosure required under this section (9) of this rule.

(16) If a provider's enrollment in the OHP program is denied, suspended, or terminated or a sanction is imposed under this rule, the providers may request a contested case hearing pursuant to OAR 410-120-1600 and 410-120-1860.

(17) The provision of health care services or items to Division clients is a voluntary action on the part of the provider. Providers are not required to serve all Division clients seeking service.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

410-120-1280 – Billing

(1) A provider enrolled with the Authority or providing services to a client in a CCO or PHP under the Oregon Health Plan (OHP) must not seek payment, from the client for any services covered by Medicaid fee-for-service or through contracted health care plans:

(a) A client cannot be billed for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Division;

(b) A client cannot be billed for services or treatments that have been denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.).

(2) For Medicaid covered services the provider must not bill the Division more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Division Program rules.

(3) Providers shall only bill a client or a financially responsible relative or representative of that client in the following situations:

(a) For any applicable coinsurance, copayments and deductibles expressly authorized in OAR chapter 410, division 120, OAR chapter 410, division 141, or any other individual Division Program rules;

(b) The client did not inform the provider of their OHP coverage, enrollment in a prepaid health plan (PHP) or coordinated care organization (CCO), or third party insurance coverage at the time of or after a service was provided, therefore, the provider could not bill the appropriate payer for reasons including, but not limited to, the lack of prior authorization, or the time limit to submit the claim for payment has passed. The provider must verify eligibility, pursuant to OAR 410-120-1140, and document attempts to obtain coverage information prior to billing the client;

(c) The client became eligible for benefits retroactively but did not meet all of the other criteria required to receive the service);

(d) A third party payer made payments directly to the client for services provided;

(e) The client has a limited benefit package: Citizen Alien Waived Emergency Medical Program (CWM) may be billed for services that are not benefits of those programs, refer to OAR 410-120-1210 for coverage. The provider must document that the client was informed in advance that the service or item would not be part of their benefit coverage by the Division. A DMAP 3165 is not required for these services;

(f) The client has requested a continuation of benefits during the contested case hearing process and the final decision was not in favor of the client. The client is responsible for any charges incurred for the denied service, on or after the effective date on the Notice of Action or Notice of Appeal Resolution. The provider must complete the DMAP 3165 pursuant to section (3)(h) of this rule before providing these services;

(g) In exceptional circumstances, a client may decide to privately pay for a covered service. In this situation, the provider may bill the client if the provider informs the client in advance of all of the following:

(A) The requested service is a covered service, and the appropriate payer (the Division, PHP, CCO or third party payer) would pay the provider in full for the covered service; and

(B) The estimated cost of the covered service, including all related charges, the amount that the appropriate payer would pay for the service, and that the provider cannot bill the client for an amount greater than the amount the appropriate payer would pay; and

(C) That the client knowingly and voluntarily agrees to pay for the covered service;

(D) The provider documents in writing, signed by the client or the client's representative, the provider gave the client the information described in (3)(g)(A-C); the client had an opportunity to ask questions, obtain additional information and consult with the client's caseworker or client representative; and the client agreed to privately pay for the service by signing an agreement incorporating all of the information described above. The client must be given a copy of the signed agreement. A provider shall not submit a claim for payment for covered services to the Division or to the client's PHP, CCO or third party payer that is subject to such agreement.

(h) A provider may bill a client for services that are not covered by the Division, PHP, or CCO (see definition of non-covered services). Before providing the non-covered service, the client must sign the provider-completed Agreement to Pay (DMAP 3165), or a facsimile containing all of the information and elements of the DMAP 3165, as shown in Table 3165 of this rule. The completed DMAP 3165, or facsimile, is valid only if the estimated fee does not change and the service is scheduled within 30 days of the client’s signature. Providers must make a copy of the completed DMAP 3165, or facsimile, available to the Division or applicable PHP or CCO upon request.

(4) Code Set requirements:

(a) Federal Code Set requirements (45 CFR 162) apply to all Medicaid Code Set requirements, including the use of diagnostic or procedure codes for prior authorization, claims submissions and payments. Code Set has the meaning established in 45 CFR 162.103 and it includes the codes and the descriptors of the codes. Federal Code Set requirements are mandatory and the Division lacks any authority to delay or alter their application or effective dates as established by the U.S. Department of Health and Human Services;

(b) The Division will adhere to the Code Set requirements in 45 CFR 162.1000 — 162.1011;

(c) Periodically, the Division will update its provider rules and tables to conform to national codes. In the event of an alleged variation between a Division-listed code and a national code, the Division will apply the national code in effect on the date of request or date of service;

(d) Only codes with limitations or requiring prior authorization are noted in rules. National Code Set issuance alone should not be construed as coverage, or a covered service by the Division;

(e) The Division adopts by reference the National Code Set revisions, deletions, and additions issued and published by the American Medical Association (Current Procedural Terminology — CPT) and on the CMS website (Healthcare Common Procedural Coding System — HCPCS). This code adoption should not be construed coverage, or a covered service by the Division.

(5) Claims:

(a) Upon submission of a claim to the Division for payment, the provider agrees that it has complied with all Division Program rules. Submission of a claim, however, does not relieve the provider from the requirement of a signed provider agreement;

(b) A provider enrolled with the Division must bill using the Authority assigned provider number, in addition to the National Provider Identification (NPI) number, if the NPI is available, pursuant to 410-120-1260;

(c) The provider must not bill the Division more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Division Program rules;

(d) Must be submitted on the appropriate form as described in the individual Division Program rules or electronically in a manner authorized in OAR chapter 943, division 120;

(e) Must be for services provided within the provider's licensure or certification;

(f) Must be submitted after (unless specified otherwise in the Division's individual Program rules):

(A) Delivery of service; or

(B) Dispensing, shipment or mailing of the item.

(g) It is the responsibility of the provider to submit true and accurate information when billing the Division. Use of a billing provider does not abrogate the performing provider's responsibility for the truth and accuracy of submitted information;

(h) A claim is considered a valid claim only if all required data is entered on or attached to the claim form. See the appropriate provider rules and supplemental information for specific instructions and requirements;

(i) A provider or its contracted agency (including billing providers) shall not submit or cause to be submitted:

(A) Any false claim for payment;

(B) Any claim altered in such a way as to result in a payment for a service that has already been paid;

(C) Any claim upon which payment has been made or is expected to be made by another source unless the amount paid or to be paid by the other party is clearly entered on the claim form;

(D) Any claim for furnishing specific care, item(s), or service(s) that have not been provided.

(j) The provider is required to submit an Individual Adjustment Request, or to refund the amount of the overpayment, on any claim where the provider identifies an overpayment made by the Division;

(k) A provider who, after having been previously warned in writing by the Division or the Department of Justice about improper billing practices, is found to have continued such improper billing practices and has had an opportunity for a contested case hearing, shall be liable to the Division for up to triple the amount of the Division established overpayment received as a result of such violation.

(6) Diagnosis code requirement:

(a) A primary diagnosis code is required on all claims, using the HIPAA nationally required diagnosis Code Set, unless specifically excluded in individual Division Program rules;

(b) All diagnosis codes are required to the highest degree of specificity;

(c) Hospitals are always required to bill using the 5th digit, in accordance with methodology used in the Medicare Diagnosis Related Groups.

(7) Procedure code requirement:

(a) For claims requiring a procedure code the provider must bill as instructed in the appropriate Division Program rules and must use the appropriate HIPAA procedure Code Set such as CPT, HCPCS, ICD-9-CM, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided;

(b) For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the client's condition and the service(s) provided. Providers must use the ICD-9-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual Division Program rules. Hospitals must follow national coding guidelines;

(c) When there is no appropriate descriptive procedure code to bill the Division, the provider must use the code for “unlisted services.” Instructions on the specific use of unlisted services are contained in the individual provider rules. A complete and accurate description of the specific care, item, or service must be documented on the claim;

(d) Where there is one CPT, CDT or HCPCS code that according to CPT, CDT and HCPCS coding guidelines or standards, describes an array of services the provider must bill the Division using that code rather than itemizing the services under multiple codes. Providers must not "unbundled" services in order to increase the Division payment.

(8) Third party Liability (TPL):

(a) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Division will be the payer of last resort;

(b) Providers must make reasonable efforts to obtain payment first from other resources. For the purposes of this rule "reasonable efforts" include determining the existence of insurance or other resources on each date of service by:

(A) Using an insurance database such as Electronic Verification System (EVS) available to the provider;

(B) Using the Automated Voice Response (AVR) or secure provider web portal on each date of service and at the time of billing.

(c) Except as noted in (8) (d) (A through E) below, when third party coverage is known to the provider, prior to billing the Division the provider must:

(A) Bill the TPL; and

(B) Except for pharmacy claims billed through the Division's point-of-sale system the provider must have waited 30 days from submission date of a clean claim and have not received payment from the third party; and

(C) Comply with the insurer's billing and authorization requirements; and

(D) Appeal a denied claim when the service is payable in whole or in part by an insurer.

(d) In accordance with federal regulations the provider must bill the TPL prior to billing the Division, except under the following circumstances:

(A) The covered health service is provided by an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID);

(B) The covered health service is provided by institutional services for the mentally and emotionally disturbed;

(C) The covered health services are prenatal and preventive pediatric services;

(D) Services are covered by a third party insurer through an absent parent where the medical coverage is administratively or court ordered;

(E) When another party may be liable for an injury or illness (see definition of Liability Insurance), the provider may bill the insurer or liable party or place a lien against a settlement or the provider may bill the Division. The provider may not both place a lien against a settlement and bill the Division. The provider may withdraw the lien and bill the Division within 12 months of the date of service. If the provider bills the Division the provider must accept payment made by the Division as payment in full.

(e) The provider must not return the payment made by the Division in order to accept payment from a liability settlement or liability insurer or place a lien against that settlement:

(A) In the circumstances outlined in (8)(d)(A through E) above, the provider may choose to bill the primary insurance prior to billing the Division. Otherwise, the Division will process the claim and, if applicable, will pay the Division allowable rate for these services and seek reimbursement from the liable third party insurance plan;

(B) In making the decision to bill the Division the provider should be cognizant of the possibility that the third party payer may reimburse the service at a higher rate than the Division, and that, once the Division makes payment no additional billing to the third party is permitted by the provider.

(f) The provider may bill the Division directly for services that are never covered by Medicare or another insurer on the appropriate form identified in the relevant provider rules. Documentation must be on file in the provider's records indicating this is a non-covered service for purposes of Third Party Resources. See the individual provider rules for further information on services that must be billed to Medicare first;

(g) Providers are required to submit an Individual Adjustment Request showing the amount of the third party payment or to refund the amount received from another source within 30 days of the date the payment is received. Failure to submit the Individual Adjustment Request within 30 days of receipt of the third party payment or to refund the appropriate amount within this time frame is considered concealment of material facts and grounds for recovery and/or sanction:

(A) When a provider receives a payment from any source prior to the submission of a claim to the Division, the amount of the payment must be shown as a credit on the claim in the appropriate field;

(B) Any provider who accepts third party payment for furnishing a service or item to a Division client after having billed the Division, shall:

(i) Submit an Individual Adjustment Request indicating the amount of the third party payment. Follow instructions in the individual Division Program rules and supplemental billing; or

(ii) When the provider has already accepted payment from the Division for the specific service or item, the provider shall make direct payment of the amount of the third party payment to the Division. The check to repay the Division shall include the reason the payment is being made and either:

(I) An Individual Adjustment Request which identifies the original claim, name and number of the client, date of service and item(s) or service(s) for which the repayment is made; or

(II) A copy of the Remittance Advice showing the original Division payment.

(C) Any provider who accepts payment from a client, or client’s representative, and is subsequently paid for the service by the Division, shall reimburse the client, or their representative, the full amount of their payment.

(h) The Division reserves the right to make a claim against any third party payer after making payment to the provider of service. The Division may pursue alternate resources following payment if it deems this a more efficient approach. Pursue alternate resources includes, but is not limited to, requesting the provider to bill the third party and to refund the Division in accordance with this rule;

(i) For services rendered to a Medicare and Medicaid dual eligible client, the Division may request the provider to submit a claim for Medicare payment and the provider must honor that request. Under federal regulation, a provider agrees not to charge a beneficiary (or the state as the beneficiary's subrogee) for services for which a provider failed to file a timely claim (42 CFR 424) with Medicare despite being requested to do so;

(j) If Medicare is the primary payer and Medicare denies payment, Medicare appeals must be timely pursued and Medicare denial must be obtained prior to submitting the claim for payment to Division. Medicare denial on the basis of failure to submit a timely appeal may result in the Division reducing from the amount of the claim any amount the Division determines could have been paid by Medicare.

(9) Full use of alternate resources:

(a) The Division will generally make payment only when other resources are not available for the client's medical needs. Full use must be made of reasonable alternate resources in the local community;

(b) Except as provided in subsection (10) of this rule, alternate resources may be available:

(A) Under a federal or state worker's compensation law or plan;

(B) For items or services furnished by reason of membership in a prepayment plan;

(C) For items or services provided or paid for directly or indirectly by a health insurance plan or as health benefits of a governmental entity, such as:

(i) Armed Forces Retirees and Dependents Act (CHAMPVA);

(ii) Armed Forces Active Duty and Dependents Military Medical Benefits Act (CHAMPUS); and

(iii) Medicare Parts A and B.

(D) To residents of another state under that state's Title XIX or state funded medical assistance programs; or

(E) Through other reasonably available resources.

(10) Exceptions:

(a) Indian Health Services or Tribal Health Facilities. Pursuant to 42 CFR 136.61 subpart G and the Memorandum of Agreement in OAR 310-146-0000, Indian Health Services facilities and tribal facilities operating under Public Law 93, Section 638 agreement are payers of last resort, and are not considered an alternate resource or TPL;

(b) Veterans Administration. Veterans who are also eligible for Medicaid benefits are encouraged to utilize Veterans' Administration facilities whenever possible. Veterans' benefits are prioritized for service related conditions and as such are not considered an alternate or TPL.

(11) Table 120-1280 – TPR codes.

(12) Table – OHP Client Agreement to Pay for Health Services, DMAP 3165.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Table 120-1280 – Third Party Resource (TPR) Explanation Codes

Use in Field “9” on the CMS-1500

Single Insurance Coverage Use when the client has only one insurance policy in addition to DMAP coverage.	
UD	Service Under Deductible
NC	Service Not Covered by Insurance Policy
PN	Patient Not Covered by Insurance Policy
IC	Insurance Coverage Cancelled/Terminated
IL	Insurance Lapsed or Not in Effect on Date of Service
IP	Insurance Payment Went to Policyholder
PP	Insurance Payment Went to Patient
NA	Service Not Authorized or Prior Authorized by Insurance
NE	Service Not Considered Emergency by Insurance
NP	Service Not Provided by Primary Care Provider/Facility
MB	Maximum Benefits Used for Diagnosis/Condition
RI	Requested Information Not Received by Insurance from Client
RP	Requested Information Not Received by Insurance from Policy holder
MV	Motor Vehicle Accident Fund Maximum Benefits Exhausted
AP	Insurance mandated under administrative/court order through an absent parent not paid within 30 days
OT	Other (if above codes do not apply, include detailed information of why no TPR payment was made)
Multiple Insurance Coverage Use when the client has more than one insurance policy in addition to DMAP coverage.	
MP	Primary Insurance Paid-Secondary Paid
SU	Primary Insurance Paid - Secondary Under Deductible
MU	Primary and Secondary Under Deductible
PU	Primary Insurance Under Deductible - Secondary Paid
SS	Primary Insurance Paid - Secondary Service Not Covered
SC	Primary Insurance Paid - Secondary Patient Not Covered
ST	Primary Insurance Paid - Secondary Insurance Cancelled/Terminated
SL	Primary Paid - Secondary Lapsed or Not in Effect
SP	Primary Paid - Secondary Payment Went to Patient
SH	Primary Paid - Secondary Payment Went to Policyholder
SA	Primary Paid - Secondary Denied - Service Not Authorized or Prior Authorized
SE	Primary Paid - Secondary Denied - Service Not Considered Emergency
SF	Primary Paid - Secondary Denied - Service Not Provided by Primary Care Provider/Facility
SM	Primary Paid - Secondary Denied - Maximum Benefits Used for Diagnosis/Condition
SI	Primary Paid - Secondary Denied - Requested Information Not Received from Policyholder
SR	Primary Paid - Secondary Denied - Requested Information Not Received from Patient

MC	Service Not Covered by Primary or Secondary Insurance
MO	Other (if above codes do not apply, include detailed information of why no TPR payment was made)

410-120-1295 – Non-Participating Provider

(1) For purposes of this rule, a provider enrolled with the Division of Medical Assistance Programs (Division) that does not have a contract with a Division-contracted Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) is referred to as a non-participating provider.

(2) For covered services that are subject to reimbursement from the CCO or PHP, a non-participating provider, other than a hospital governed by (3) below, must accept from the Division-contracted CCO or PHP, as payment in full, the amount that the provider would be paid from the Division if the client was fee-for-service (FFS).

(3) For covered services provided on and after October 1, 2011, the Division-contracted CCO or Fully Capitated Health Plan (FCHP) that does not have a contract with a hospital, is required to reimburse, and hospitals are required to accept as payment in full, the following reimbursement:

(a) Non-participating Type A and Type B hospital: The CCO or FCHP shall reimburse a non-participating Type A and Type B hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the global payments to the CCO for the contract period or for the capitation rates paid to the FCHP for the contract period. (ORS 414.727);

(b) All other non-participating hospitals (not designated as a rural access or Type A and Type B hospital): As specified in ORS 414.743, the CCO or FCHP shall reimburse inpatient and outpatient services using a Medicare payment methodology at a specified percentage point less than the percentage of Medicare costs used by the Oregon Health Authority (Authority) when calculating the base hospital capitation payment to the CCO or FCHP's, excluding any supplemental payments.

(i) Effective for services on or after October 1, 2011, for a hospital providing 10 percent or more of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 64 percent;

(ii) Effective for services on or after October 1, 2011, for a hospital providing less than 10 percent of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 66 percent.

(4) A non-participating hospital must notify the CCO or FCHP within 2 business days of an CCO or FCHP patient admission when the CCO or FCHP is the primary payer. Failure to notify does not, in and of itself, result in denial for payment. The CCO or FCHP is required to review the hospital claim for:

(a) Medical appropriateness;

(b) Compliance with emergency admission or prior authorization policies;

(c) Member's benefit package;

(d) The CCO or FCHP contract and the Division's administrative rules.

(5) After notification from the non-participating hospital, the CCO or FCHP may:

(a) Arrange for a transfer to a contracted facility, if the patient is medically stable and the CCO or FCHP has secured another facility to accept the patient;

(b) Perform concurrent review; and/or

(c) Perform case management activities.

(6) In the event of a disagreement between the CCO or FCHP and hospital, the provider may appeal the decision by asking for an administrative review as specified in OAR 410-120-1580.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.705 & 414.743

410-120-1300 – Timely Submission of Claims

(1) All claims for services must be submitted within 12 months of the date of service. The date of service for an inpatient hospital stay is considered the date of discharge.

(2) A claim that was submitted within 12 months of the date of service, but that was denied, may be resubmitted within 18 months of the date of service. These claims must be submitted to the Division of Medical Assistance Programs (Division) at the address listed in the provider Contacts document. The provider must present documentation acceptable to the Division verifying the claim was originally submitted within 12 months of the date of service, unless otherwise stated in individual provider rules. Acceptable documentation is:

(a) A remittance advice from the Division that shows the claim was submitted before the claim was one year old;

(b) A copy of a billing record or ledger showing dates of submission to the Division.

(3) Exceptions to the 12-month requirement that may be submitted to the Division are as follows:

(a) When the Division or the client's branch office has made an error that caused the provider not to be able to bill within 12 months of the date of service. The Division must confirm the error;

(b) When a court or an Administrative Law Judge has ordered the Division to make payment;

(c) When the Authority determines a client is retroactively eligible for Division medical coverage and more than 12 months have passed between the date of service and the determination of the client's eligibility.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.019, 414.025, 414.065

2-1-10 7-1-10 (Hk only) 7-1-11 (Hk)

410-120-1320 – Payment Authorization of Payment

(1) Some services or items covered by the Division of Medical Assistance Programs (Division) require authorization before the service can be provided. See the appropriate Division rules for information on services requiring authorization and the process to be followed to obtain authorization.

(2) Documentation submitted when requesting authorization must support the medical justification for the service. A complete request is one that contains all necessary documentation and meets any other requirements as described in the appropriate Division rules.

(3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

(4) The Division will not make payment for authorized services under the following circumstances:

(a) The client was not eligible at the time services were provided. The provider is responsible for checking the client's eligibility each time services are provided;

(b) The provider cannot produce appropriate documentation to support medical appropriateness, or the appropriate documentation was not submitted to the authorizing agency;

(c) The service has not been adequately documented (see 410-120-1360, Requirements for Financial, Clinical and Other Records); that is, the documentation in the provider's files is not adequate to determine the type, medical appropriateness, or quantity of services provided and required documentation is not in the provider's files;

(d) The services billed or provided are not consistent with the information submitted when authorization was requested or the services provided are determined retrospectively not to be medically appropriate;

(e) The services billed are not consistent with those provided;

(f) The services were not provided within the timeframe specified on the authorization of payment document;

(g) The services were not authorized or provided in compliance with the rules in these General Rules and in the appropriate provider rules.

(5) Retroactive authorizations:

(a)Authorization for payment may be given for a past date of service if:

(A) The client was made retroactively eligible or was retroactively disenrolled from a CCO or PHP on the date of service;

(B) The services provided meet all other criteria and Oregon Administrative Rules, and;

(C) The request for authorization is received within 90 days of the date of service;

(b) Any requests for authorization after 90 days from date of service require documentation from the Provider that authorization could not have been obtained within 90 days of the date of service.

(7) Payment authorization is valid for the time period specified on the authorization notice, but not to exceed 12 months, unless the Client's benefit package no longer covers the service, in which case the authorization will terminate on the date coverage ends.

(8) When clients have other health care coverage (third-party resources, or TPR), the Division only requires payment authorization for the services that TPR does not cover. Examples include:

(a) When Medicare is the primary payer for a service, no payment authorization from the Division is required, unless specified in the appropriate Division program rules;

(b) When other TPR is primary, such as Blue Cross, CHAMPUS, etc., the Division requires payment authorization when the other insurer or resource does not cover the service or reimburses less than the Division rate.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

[HK 10/2/14 – 410-120-1320(5)(c) changed to (5)(b)]

410-120-1340 – Payment (T)

(1) The Division of Medical Assistance Programs (Division) shall make payment only to the enrolled provider (see OAR 410-120-1260) who actually performs the service or to the provider's enrolled billing provider for covered services rendered to eligible clients.

(2) Division reimbursement for services may be subject to review prior to reimbursement.

(3) The Division that is administering the program under which the billed services or items are provided sets fee-for-service (FFS) payment rates.

(4) The Division uses FFS payment rates in effect on the date of service that are the lesser of:

(a) The amount billed;

(b) The Division maximum allowable amount or;

(c) Reimbursement specified in the individual program provider rules.

(5) Amount billed may not exceed the provider's "usual charge" (see definitions).

(6) The Division's maximum allowable rate setting process uses the following methodology for:

(a) Relative Value Unit (RVU) weight-based rates: For all CPT/HCPCS codes assigned an RVU weight, the 2015 Total RVU weights published in the Federal Register, Vol. 79, November 13, 2014 to be effective for dates of services on or after January 1, 2015:

(A) For professional services not typically performed in a facility, the Non-Facility Total RVU weight;

(B) For professional services typically performed in a facility, the Facility Total RVU weight;

(C) The Division applies the following conversion factors:

(i) $40.79 for labor and delivery codes (59400-59622);

(ii) $36.0666 for Federally Qualified primary care codes billed by providers meeting the criteria in OAR 410-130-0005 for dates of service between January 1, 2013 and December 31, 2014;

(iii) $27.82 for Oregon primary care providers and services not specified in sub-paragraph (ii). A current list of primary care CPT, HCPCs, and provider specialty codes is available at http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml.

(iv) $25.48 for all remaining RVU weight based CPT/HCPCS codes.

(D) Rate calculation: Effective January 1, 2015, the Division shall calculate rates for each RVU weight-based code using statewide Geographic Practice Cost Indices (GPCIs) as follows:

(i) Work RVU) X (Work GPCI of 1) + (Practice Expense RVU) X (Practice GPCI of 0.974) + (Malpractice RVU) X (Malpractice GPCI of 0.708);

(ii) Sum in paragraph (D)(i) multiplied by the applicable conversion factor in paragraph (C).

(b) Non RVU based rates:

(A) $20.78 is the base rate for anesthesia service codes 00100-01996. The rate is based on per unit of service;

(B) Clinical lab codes are priced at 70 percent of the 2015 Medicare clinical lab fee schedule;

(C) All approved Ambulatory Surgical Center (ASC) procedures are reimbursed at 80 percent of the 2014 Medicare fee schedule;

(D) Physician administered drugs, billed under a HCPCS code, are based on Medicare's Average Sale Price (ASP). When no ASP rate is listed, the rate shall be based upon the Wholesale Acquisition Price (WAC) plus 6.25 percent. If no WAC is available, then the rate shall be reimbursed at Acquisition Cost. Pricing information for WAC is provided by First Data Bank. These rates may change periodically based on drug costs;

(E) All procedures used for vision materials and supplies are based on contracted rates that include acquisition cost plus shipping and handling;

(F) Individual provider rules may specify reimbursement rates for particular services or items.

(7) The rates in section (6) are updated periodically and posted on the Authority web site at http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml.

(8) The Division reimburses inpatient hospital service under the DRG methodology, unless specified otherwise in the Hospital Services program administrative rules

(chapter 410, division 125). Reimbursement for services, including claims paid at DRG rates, may not exceed any upper limits established by federal regulation.

(9) The Division reimburses all out-of-state hospital services at Oregon DRG or FFS rates as published in the Hospital Services Program rules (OAR chapter 410, division 125) unless the hospital has a contract or service agreement with the Division to provide highly specialized services.

(10) Payment rates for in-home services provided through Department of Human Services (Department) Aging and People with Disabilities (APD) may not exceed the costs of nursing facility services unless the criteria in OAR 411-027-0020 have been met.

(11) The Division sets payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities and psychiatric and rehabilitative care facilities at a rate that is:

(a) Consistent with similar services provided in the State of Oregon; and

(b) The lesser of the rate paid to the most similar facility licensed in the State of Oregon or the rate paid by the Medical Assistance Programs in that state for that service; or

(c) The rate established by APD for out-of-state nursing facilities.

(12) The Division may not make payment on claims that have been assigned, sold, or otherwise transferred or when the billing provider, billing agent, or billing service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a provider for accounts receivable.

(13) The Division may not make a separate payment or copayment to a nursing facility or other provider for services included in the nursing facility's all-inclusive rate. The following services are not included in the all-inclusive rate (OAR 411-070-0085) and may be separately reimbursed:

(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services Program administrative rules (chapter 410, division 121) and Home Enteral/Parenteral Nutrition and IV Services Program administrative rules (chapter 410, division 148);

(b) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the appropriate program administrative rules (chapter 410, division 129 and 131);

(c) Continuous oxygen that exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122);

(d) Influenza immunization serum as described in the Pharmaceutical Services program administrative rules (chapter 410, division 121);

(e) Podiatry services provided under the rules in the Medical-Surgical Services program administrative rules (chapter 410, division 130);

(f) Medical services provided by a physician or other provider of medical services, such as radiology and laboratory, as outlined in the Medical-Surgical Services program rules (chapter 410, division 130);

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122).

(14) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSA's). A separate payment may not be made for services included in the core package of services as outlined in OAR chapter 410, division 142.

(15) Payment for Division clients with Medicare and full Medicaid:

(a) The Division limits payment to the Medicaid allowed amount, less the Medicare payment, up to the Medicare co-insurance and deductible, whichever is less. The Division's payment may not exceed the co-insurance and deductible amounts due;

(b) The Division pays the allowable rate for covered services that are not covered by Medicare.

(16) For clients with third-party resources (TPR), the Division pays the allowed rate less the TPR payment but not to exceed the billed amount.

(17) The Division payments, including contracted PHP or CCO payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For the Division, payment in full includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding Division allowable payment; and

(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain payment authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual provider rules.

(18) Payment by the Division does not restrict or limit the Authority or any state or federal oversight entity's right to review or audit a claim before or after the payment. Claim payment may be denied or subject to recovery if medical review, audit, or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care or medical appropriateness of the care or payment.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.033, 414.065, 414.095, 414.727, 414.728, 414.742 & 414.743

410-120-1350 – Buying-Up

(1) Providers are not permitted to bill and accept payment from the Division of Medical Assistance Programs (Division) or a managed care plan for a covered service:

(a) When a non-covered service has been provided; and

(b) Additional payment is sought or accepted from the Division client.

(2) Examples include, but are not limited to, charging the client an additional payment to obtain a gold crown (non-covered) instead of the stainless steel crown (covered) or charging an additional client payment to obtain eyeglass frames not on the Division or managed care plan contract.

(3) If a client wants to purchase a non-covered service or item, the client must be responsible for full payment. Division or managed care plan payment for a covered service cannot be credited toward the non-covered service.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025 & 414.065

410-120-1360 – Requirements for Financial, Clinical and Other Records

The Oregon Health Authority (Authority) is responsible for analyzing and monitoring the operation of the Division of Medical Assistance Programs (Division) and for auditing and verifying the accuracy and appropriateness of payment, utilization of services, medical necessity, medical appropriateness, the quality of care, and access to care. The provider or the provider's designated billing service or other entity responsible for the maintenance of financial, clinical, and other records, shall:

(1) Develop and maintain adequate financial and clinical records and other documentation which supports the specific care, items, or services for which payment has been requested. Payment will be made only for services that are adequately documented. Documentation must be completed before the service is billed to the Division:

(a) All records must document the specific service provided, the number of services or items comprising the service provided, the extent of the service provided, the dates on which the service was provided, and the individual who provided the service. Patient account and financial records must also include documentation of charges, identify other payment resources pursued, indicate the date and amount of all debit or credit billing actions, and support the appropriateness of the amount billed and paid. For cost reimbursed services, the provider is required to maintain adequate records to thoroughly explain how the amounts reported on the cost statement were determined. The records must be accurate and in sufficient detail to substantiate the data reported;

(b) Clinical records, including records of all therapeutic services, must document the client's diagnosis and the medical need for the service. The client's record must be annotated each time a service is provided and signed or initialed by the individual who provided the service or must clearly indicate the individual(s) who provided the service. Information contained in the record must be appropriate in quality and quantity to meet the professional standards applicable to the provider or practitioner and any additional standards for documentation found in this rule, the individual provider rules and any pertinent contracts;

(c) Have policies and procedures to ensure the maintenance of the confidentiality of medical record information. These procedures ensure the provider may release such information in accordance with federal and state statutes, ORS 179.505 through 179.507, 411.320, 433.045, 42 CFR part 2, 42 CFR subpart F, 45 CFR 205.50, including ORS 433.045(3) with respect to HIV test information.

(2) Retain clinical records for seven years and financial and other records described in subsections (a) and (b) of this rule for at least five years from the date(s) of service.

(3) Upon written request from the Authority, the Medicaid Fraud Unit, Oregon Secretary of State, or the Department of Health and Human Services (DHHS), or their authorized

representatives, furnish requested documentation immediately or within the time-frame specified in the written request. Copies of the documents may be furnished unless the originals are requested. At their discretion, official representatives of the Authority, Department, Medicaid Fraud Unit, or DHHS, may review and copy the original documentation in the provider's place of business. Upon the written request of the provider, the Program or the Unit may, at their sole discretion, modify or extend the time for provision of such records if, in the opinion of the Program or Unit good cause for such extension is shown. Factors used in determining whether good cause exists include:

(a) Whether the written request was made in advance of the deadline for production;

(b) If the written request is made after the deadline for production, the amount of time elapsed since that deadline;

(c) The efforts already made to comply with the request;

(d) The reasons the deadline cannot be met;

(e) The degree of control that the provider had over its ability to produce the records prior to the deadline;

(f) Other extenuating factors.

(4) Access to records, inclusive of medical charts and financial records does not require authorization or release from the client if the purpose of such access is:

(a) To perform billing review activities; or

(b) To perform utilization review activities; or

(c) To review quality, quantity, medical appropriateness of care, items, and services provided; or

(d) To facilitate payment authorization and related services; or

(e) To investigate a client's fair hearing request; or

(f) To facilitate investigation by the Medicaid Fraud Unit or DHHS; or

(g) Where review of records is necessary to the operation of the program.

(5) Failure to comply with requests for documents and within the specified time-frames means that the records subject to the request may be deemed by the Authority not to exist for purposes of verifying appropriateness of payment, medical appropriateness, the quality of care, and the access to care in an audit or overpayment determination,

and accordingly subjects the provider to possible denial or recovery of payments made by the Division or to sanctions.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.115, 414.125, 414.135, 414.145

410-120-1380 – Compliance with Federal and State Statutes

(1) When a provider submits a claim for medical services or supplies provided to a Division of Medical Assistance Programs (Division) client, the Division will deem the submission as a representation by the medical provider to the Medical Assistance Program of the medical provider's compliance with the applicable sections of the federal and state statutes referenced in this rule:

(a) 45 CFR Part 84 which implements Title V, Section 504 of the Rehabilitation Act of 1973;

(b) 42 CFR Part 493 Laboratory Requirements and ORS 438 (Clinical Laboratories).

(c) Unless exempt under 45CFR Part 87 for Faith-Based Organizations (Federal Register, July 16, 2004, Volume 69, #136), or other federal provisions, the provider must comply and, as indicated, cause all subcontractors to comply with the following federal requirements to the extent that they are applicable to the goods and services governed by these rules. For purposes of these rules, all references to federal and state laws are references to federal and state laws as they may be amended from time to time:

(A) The provider must comply and cause all subcontractors to comply with all federal laws, regulations, executive orders applicable to the goods and services provided under these rules. Without limiting the generality of the foregoing, the provider expressly agrees to comply and cause all subcontractors to comply with the following laws, regulations and executive orders to the extent they are applicable to the goods and services provided under these rules:

(i) Title VI and VII of the Civil Rights Act of 1964, as amended;

(ii) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended;

(iii) The Americans with Disabilities Act of 1990, as amended;

(iv) Executive Order 11246, as amended;

(v) The Health Insurance Portability and Accountability Act of 1996;

(vi) The Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended;

(vii) The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (viii) all regulations and administrative rules established pursuant to the foregoing laws;

(viii) All other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations;

(ix) All federal law governing operation of Community Mental Health Programs, including without limitation, all federal laws requiring reporting of client abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the goods and services governed by these rules and required by law to be so incorporated. No federal funds may be used to provide services in violation of 42 USC 14402.

(B) Any provider that receives or makes annual payments under the Title XIX State Plan of at least $5,000,000, as a condition of receiving such payments, shall:

(i) Establish written policies for all employees of the entity (including management), and of any contractor, subcontractor, or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any Oregon State laws pertaining to civil or criminal penalties for false claims and statements, and whistle blowing protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

(ii) Include as part of written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse; and

(iii) Include in any employee handbook for the entity, a specific discussion of the laws described in (i), the rights of the employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(C) If the goods and services governed under these rules exceed $10,000, the provider must comply and cause all subcontractors to comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in the Department of Labor regulations (41 CFR Part 60);

(D) If the goods and services governed under these rules exceed $100,000, the provider must comply and cause all subcontractors to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act—33 U.S.C. 1251 to 1387), specifically

including, but not limited to, Section 508 (33 U.S.C. 1368). Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 32), which prohibit the use under non-exempt Federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations must be reported to the Oregon Health Authority (Authority), the federal Department of Health and Human Services (DHHS) and the appropriate Regional Office of the Environmental Protection Agency. The provider must include and cause all subcontractors to include in all contracts with subcontractors receiving more than $100,000, language requiring the subcontractor to comply with the federal laws identified in this section;

(E) The provider must comply and cause all subcontractors to comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act, 42 U.S.C. 6201 et seq. (Pub. L. 94-163);

(F) The provider certifies, to the best of the provider's knowledge and belief, that:

(i) No federal appropriated funds have been paid or will be paid, by or on behalf of the provider, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement;

(ii) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the provider must complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions;

(iii) The provider must require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients and subcontractors must certify and disclose accordingly;

(iv) This certification is a material representation of fact upon which reliance was placed when this provider agreement was made or entered into. Submission of this certification is a prerequisite for making or entering into this provider agreement imposed by section 1352, Title 31, U.S. Code. Any

person who fails to file the required certification will be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

(G) If the goods and services funded in whole or in part with financial assistance provided under these rules are covered by the Health Insurance Portability and Accountability Act or the federal regulations implementing the Act (collectively referred to as HIPAA), the provider agrees to deliver the goods and services in compliance with HIPAA. Without limiting the generality of the foregoing, goods and services funded in whole or in part with financial assistance provided under these rules are covered by HIPAA. The provider must comply and cause all subcontractors to comply with the following:

(i) Individually Identifiable Health Information about specific individuals is confidential. Individually Identifiable Health Information relating to specific individuals may be exchanged between the provider and the Authority for purposes directly related to the provision to clients of services that are funded in whole or in part under these rules. However, the provider must not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate the Authority Privacy Rules, OAR 410-014-0000 et. seq., or the Authority's Notice of Privacy Practices, if done by the Authority. A copy of the most recent the Authority Notice of Privacy Practices is posted on the Authority Web site or may be obtained from the Authority;

(ii) If the provider intends to engage in Electronic Data Interchange (EDI) transactions with the Authority in connection with claims or encounter data, eligibility or enrollment information, authorizations or other electronic transactions, the provider must execute an EDI Trading Partner Agreement with the Authority and must comply with the Authority EDI rules;

(iii) If a provider reasonably believes that the provider's or the Authority' data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, the provider must promptly consult the Authority Privacy Officer. The provider or the Authority may initiate a request to test HIPAA transactions, subject to available resources and the Authority testing schedule.

(H) The provider must comply and cause all subcontractors to comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 USC 6901 et. seq.). Section 6002 of that Act (codified at 42 USC 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Parts 247;

(I) The provider must comply and, if applicable, cause a subcontractor to comply, with the applicable audit requirements and responsibilities set forth in the Office of Management and Budget Circular A-133 entitled “Audits of States, Local Governments and Non-Profit Organizations;”

(J) The provider must not permit any person or entity to be a subcontractor if the person or entity is listed on the non-procurement portion of the General Service Administration’s “List of Parties Excluded from Federal Procurement or Non-procurement Programs” in accordance with Executive Orders No. 12,549 and No. 12,689, “Debarment and Suspension”. (See 45 CFR part 76). This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and providers and subcontractors declared ineligible under statutory authority other than Executive Order No. 12549. Subcontractors with awards that exceed the simplified acquisition threshold must provide the required certification regarding their exclusion status and that of their principals prior to award;

(K) The provider must comply and cause all subcontractors to comply with the following provisions to maintain a drug-free workplace:

(i) The provider certifies that it will provide a drug-free workplace by publishing a statement notifying its employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, except as may be present in lawfully prescribed or over-the-counter medications, is prohibited in the provider's workplace or while providing services to Authority clients. The provider's notice must specify the actions that will be taken by the provider against its employees for violation of such prohibitions;

(ii) Establish a drug-free awareness program to inform its employees about the dangers of drug abuse in the workplace, the provider's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations;

(iii) Provide each employee to be engaged in the performance of services under these rules a copy of the statement mentioned in paragraph (J)(i) above;

(iv) Notify each employee in the statement required by paragraph (J)(i) that, as a condition of employment to provide services under these rules, the employee will abide by the terms of the statement and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction;

(v) Notify the Authority within ten (10) days after receiving notice under subparagraph (J)(iv) from an employee or otherwise receiving actual notice of such conviction;

(vi) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program by any employee who is so convicted as required by Section 5154 of the Drug-Free Workplace Act of 1988;

(vii) Make a good-faith effort to continue a drug-free workplace through implementation of subparagraphs (J)(i) through (J)(vi);

(viii) Require any subcontractor to comply with subparagraphs (J)(i) through (J)(vii);

(ix) Neither the provider, nor any of the provider's employees, officers, agents or subcontractors may provide any service required under these rules while under the influence of drugs. For purposes of this provision, "under the influence" means observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the provider or provider's employee, officer, agent or subcontractor has used a controlled substance, prescription or non-prescription medication that impairs the provider or provider's employee, officer, agent or subcontractor's performance of essential job function or creates a direct threat to Authority clients or others. Examples of abnormal behavior include, but are not limited to hallucinations, paranoia or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to slurred speech, difficulty walking or performing job activities;

(x) Violation of any provision of this subsection may result in termination of the provider agreement under these rules.

(L) The provider must comply and cause all sub-contractors to comply with the Pro-Children Act of 1994 (codified at 20 USC section 6081 et. seq.);

(M) The provider must comply with all applicable federal and state laws and regulations pertaining to the provision of Medicaid Services under the Medicaid Act, Title XIX, 42 USC Section 1396 et. Seq., and CHIP benefits established by Title XXI of the Social Security Act, including without limitation:

(i) Keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving Medicaid assistance and must furnish such information to any state or federal agency responsible for administering the Medicaid program regarding any payments claimed by such person or institution for providing Medicaid Services as the state or federal

agency may from time to time request. 42 USC Section 1396a(a)(27); 42 CFR 431.107(b)(1) & (2); 42 CFR 457.950(a)(3);

(ii) Comply with all disclosure requirements of 42 CFR 1002.3(a) and 42 CFR 455 Subpart (B); 42 CFR 457.950(a)(3);

(iii) Maintain written notices and procedures respecting advance directives in compliance with 42 USC Section 1396(a)(57) and (w), 42 CFR 431.107(b)(4), and 42 CFR 489 subpart I;

(iv) Certify when submitting any claim for the provision of Medicaid Services that the information submitted is true, accurate and complete. The provider must acknowledge provider’s understanding that payment of the claim will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

(2) Hospitals, nursing facilities, home health agencies (including those providing personal care), hospices and Health Maintenance Organizations will comply with the Patient Self-Determination Act as set forth in Section 4751 of OBRA 1991. To comply with the obligation under the above listed laws to deliver information on the rights of the individual under Oregon law to make health care decisions, the named providers and organizations will give capable individuals over the age of 18 a copy of "Your Right to Make Health Care Decisions in Oregon," copyright 1993, by the Oregon State Bar Health Law Section. Out-of-State providers of these services should comply with Medicare, Medicaid and CHIP regulations in their state. Submittal to the Division of the appropriate billing form requesting payment for medical services provided to a Medicaid/CHIP eligible client shall be deemed representation to the Division of the medical provider's compliance with the above-listed laws.

(3) Providers described in ORS chapter 419B are required to report suspected child abuse to their local Department Children, Adults and Families office or police, in the manner described in ORS 419.

(4) The Clinical Laboratory Improvement Act (CLIA), requires all entities that perform even one laboratory 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.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-120-1385 – Compliance with Public Meetings Law

(1) Advisory committees with the authority to make decisions for, conduct policy research for, or make recommendations on administration or policy related to the medical assistance programs operated by the Oregon Health Authority (Authority) pursuant to ORS Chapter 414 must comply with provisions of ORS 192.610 to 192.690 -- Public Meetings Law.

(2) This rule applies to those advisory committees of the medical assistance programs operated under ORS Chapter 414 that are both:

(a) Created by state constitution, statutes, administrative rule, order, intergovernmental agreement, or other official act, including direct or delegated authority from the Director of the Authority; and

(b) Comprised of at least two committee members who are not employed by a public body.

(3) Advisory committees subject to this rule must comply with the following provisions:

(a) Meetings must be open to public attendance unless an executive session is authorized. Committees must meet in a place accessible to persons with disabilities and, upon request, shall make a good faith effort to provide a sign language interpreter for persons with hearing impairment;

(b) Groups must provide advanced notice of meetings, location, and principal subjects to be discussed. Posting notices on the Web site operated by the Division of Medical Assistance Programs (Division) will be sufficient compliance of the advanced notice requirement. Interested persons, including news media, may request hard copy notices by contacting the Division's Client and Provider Education Unit;

(c) Groups must take minutes at meetings and make them available to the public upon request to the contact person identified on the public notice;

(d) Any meeting that is held through the use of telephone or other electronic communication must be conducted in accordance with the Public Meetings Law.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025, 414.065 & 414.227

410-120-1390 - Premium Sponsorships

(1) Premium donations made for the benefit of one or more specified Division of Medical Assistance Programs (Division) clients will be referred to as a “premium sponsorship” and the donor shall be referred to as a “sponsor.”

(2) The Oregon Health Authority (Authority) may accept premium sponsorships consistent with the requirements of this rule. The Authority may adopt such forms and reporting requirements, and change the forms and reporting requirements, as necessary to carry out its functions under this rule. The Authority may identify one or more designees to perform one or more of the functions of the Authority under this rule.

(3) This rule does not create or establish any premium sponsorship program. The Authority does not operate or administer a premium sponsorship program. The Authority does not find sponsors for clients or take requests or applications from clients to be sponsored.

(4) This rule does not create a right for any Authority client to be sponsored. Premium sponsorship is based solely on the decisions of sponsors. The Authority only applies the premium sponsorship funds that are accepted by the Authority as instructed by the sponsor. The Authority does not determine who may be sponsored. Any operations of a premium sponsorship program are solely the responsibility of the sponsoring entity.

(5) A premium sponsorship amount that is not actually received by the Authority client will not be deemed to be cash or other resource attributed to the Authority client, except to the extent otherwise required by federal law. A Authority client's own payment of his or her obligation, or payment made by an authorized representative of the Authority client, is not a sponsorship except to the extent that the authorized representative is otherwise subject to subsection (8) of this rule.

(6) Nothing in this rule alters the Authority client's personal responsibility for assuring that his or her own payments (including current or past due premium payments) are made on time as required under any Authority rule.

(7) If the Authority accepts a premium sponsorship payment for the benefit of a specified client, the Authority or its designee will credit the amount of the sponsorship payment toward any outstanding amount owed by the specified client. The Authority or its designee is not responsible for notifying the client that a premium sponsorship payment is made or that a sponsorship payment has stopped being made.

(8) If a sponsor is a health care provider, or an entity related to a health care provider, or an organization making a donation on behalf of such provider or entity, the following requirements apply:

(a) The Authority will decline to accept premium sponsorships that are not "bona fide donations" within the meaning of 42 CFR 433.54. A premium sponsorship is a "bona

fide donation" if the sponsorship has no direct or indirect relationship to Medicaid payments made to a health care provider, a related entity providing health care items or services, or other providers furnishing the same class of items or services as the provider or entity;

(b) For purposes of this rule, terms "health care provider," "entity related to a health care provider" and "provider-related donation" will have the same meaning as those terms are defined in 42 CFR 433.52. A health care provider includes but is not limited to any provider enrolled with the Authority or contracting with a Prepaid Health Plan for services to Oregon Health Plan clients.

(c) premium sponsorships made to the Authority by a health care provider or an entity related to a health care provider do not qualify as a "bona fide donation" within the meaning of subsection (a) of this section, and the Authority will decline to accept such sponsorships;

(d) If a health care provider or an entity related to a health care provider donates money to an organization, which in turn donates money in the form of a premium sponsorship to the Authority, the organization will be referred to as an organizational sponsor. The Authority may accept premium sponsorship from an organizational sponsor if the organizational sponsor has completed the initial the Authority certification process and complies with this rule. An organizational sponsor may not itself be a health care provider, provider-related entity, or a unit of local government;

(e) All organizational sponsors that make premium sponsorships to the Authority may be required to complete at least annual certifications, but no more frequently than quarterly. Reports submitted to the Authority will include information about the percentage of its revenues that are from donations by providers and provider-related entities. The organization's chief executive officer or chief financial officer must certify the report. In its certification, the organizational sponsor must agree that its records may be reviewed to confirm the accuracy, completeness and full disclosure of the donations, donation amounts and sources of donations. The Authority will decline to accept donations or gifts from an organization that refuses or fails to execute necessary certifications or to provide access to documentation upon request;

(f) The Authority will decline to accept premium sponsorships from an organizational sponsor if the organization receives more than 25 percent of its revenue from donations from providers or provider-related entities during the State's fiscal year;

(g) Any health care provider or entity related to a health care provider making a donation to an organizational sponsor, or causing another to make a premium sponsorship on its behalf, and any organizational sponsor, is solely responsible for compliance with laws and regulations applicable to any donation, including but not limited to 42 CFR 1001.951 and 1001.952.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025 & 414.065

410-120-1395 – Program Integrity

(1) The Oregon Health Authority (Authority) uses several approaches to promote program integrity. These rules describe program integrity actions related to provider payments. Our program integrity goal is to pay the correct amount to a properly enrolled provider for covered, medically appropriate services provided to an eligible client according to the client's benefit package of health care services in effect on the date of service. Types of program integrity activities include but are not limited to the following activities:

(a) Medical review and prior authorization processes, including all actions taken to determine the medical appropriateness of services or items;

(b) Provider obligations to submit correct claims;

(c) Onsite visits to verify compliance with standards;

(d) Implementation of Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards to improve accuracy and timeliness of claims processing and encounter reporting;

(e) Provider credentialing activities;

(f) Accessing federal Department of Health and Human Services database (exclusions);

(g) Quality improvement activities;

(h) Cost report settlement processes;

(i) Audits;

(j) Investigation of fraud or prohibited kickback relationships;

(k) Coordination with the Department of Justice Medicaid Fraud Control Unit (MFCU) and other health oversight authorities.

(2) Providers must maintain clinical, financial and other records, capable of being audited or reviewed, consistent with the requirements of OAR 410120-1360, Requirements for Financial, Clinical and Other Records, in the General Rules Program, the Oregon Health Plan administrative rules, and the rules applicable to the service or item.

(3) The following people may review a request for services or items, or audit a claim for care, services or items, before or after payment, for assurance that the specific care, item or service was provided in accordance with the Division of Medical Assistance

Program's (Division) rules and the generally accepted standards of a provider's field of practice or specialty:

(a) Authority, Department staff or designee; or

(b) Medical utilization and review contractor; or

(c) Dental utilization and review contractor; or

(d) Federal or state oversight authority.

(4) Payment may be denied or subject to recovery if the review or audit determines the care, service or item was not provided in accordance with Division rules or does not meet the criteria for quality or medical appropriateness of the care, service or item or payment. Related provider and Hospital billings will also be denied or subject to recovery.

(5) When the Authority determines that an overpayment has been made to a provider, the amount of overpayment is subject to recovery.

(6) The Authority may communicate with and coordinate any program integrity actions with the MFCU, DHHS, and other federal and state oversight authorities.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025 & 414.065

410-120-1397 – Recovery of Overpayments to Providers — Recoupments and Refunds

(1) The Oregon Health Authority (Authority) requires providers to submit true, accurate, and complete claims or encounters. The Authority treats the submission of a claim or encounter, whether on paper or electronically, as certification by the provider of the following: "This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim or encounter will be from federal and state funds, and that any falsification or concealment of a material fact maybe prosecuted under federal and state laws."

(2) Authority staff or a designee may review or audit a claim before or after payment for assurance that the specific care, item or service was provided in accordance with Authority rules and policies, the terms applicable to the agreement or contract and the generally accepted standards of a provider's field of practice or specialty:

(a) "Designee" for the purposes of these rules includes, but is not limited to, a medical, behavioral, drug or dental utilization and review or a post-payment review contractor;

(b) "Claim" for the purposes of these rules includes requests for payment under a provider enrollment agreement or contract, whether submitted as a claim or invoice or other method for requesting payment authorized by administrative rule, and may include encounter data.

(3) The Authority may deny payment or may deem payments subject to recovery as an overpayment if a review or audit determines the care, item, drug or service was not provided in accordance with Authority policy and rules applicable agreement, intergovernmental agreement or contract, including but not limited to the reasons identified in section (5) of this rule. Related provider and hospital billings will also be denied or subject to recovery.

(4) If a provider determines that a submitted claim or encounter is incorrect, the provider is obligated to submit an Individual Adjustment Request and refund the amount of the overpayment, if any, consistent with the requirements of OAR 410-120-1280. When the provider determines that an overpayment has been made, the provider must notify and reimburse the Authority immediately, following one of the reimbursement procedures described below:

(a) Submitting a Medicaid adjustment form (DMAP 1036-Individual Adjustment Request) will result in an offset of future payments. It is not necessary to refund with a check if an offset of future payments is adequate to repay the amount of the overpayment; or

(b) Providers preferring to make a refund by check must attach a copy of the remittance statement page indicating the overpayment information, except as

provided by subsection (c) of this section. If the overpayment involves an insurance payment or another third party resource, providers will attach a copy of the remittance statement from the insurance payer:

(A) Refund checks not involving third party Resource payments will be made payable to Division Receipting -- Checks in Salem;

(B) Refunds involving third party resource payments will be made payable and submitted to Division Receipting -- MPR Checks in Salem;

(c) Providers making a refund by check based on audit or post-payment review will follow the reimbursement procedures described in the overpayment notice or order in the audit or on post-payment review, if specified.

(5) The Authority may determine, as a result of review or other information, that a payment should be denied or that an overpayment has been made to a provider, which indicates that a provider may have submitted claims or encounters, or received payment to which the provider is not properly entitled. Such payment denial or overpayment determinations may be based on, but not limited to, the following grounds:

(a) The Authority paid the provider an amount in excess of the amount authorized under the state plan or Authority rule, agreement or contract;

(b) A third party paid the provider for services (or a portion thereof) previously paid by the Authority;

(c) The Authority paid the provider for care, items, drugs or services that the provider did not perform or provide;

(d) The Authority paid for claims submitted by a data processing agent for whom a written provider or billing agent/billing service agreement or other applicable contract or agreement was not on file at the time of submission;

(e) The Authority paid for care, items, drugs or services and later determined they were not part of the client's benefit package;

(f) Coding, processing submission or data entry errors;

(g) The care, items, drugs or service was not provided in accordance with the Authority rules or does not meet the criteria for quality of care, item, drug or service, or medical appropriateness of the care, item, drug, service or payment;

(h) The Authority paid the provider for care, items, drugs or services, when the provider did not comply with Authority rules and requirements for reimbursement.

(6) Prior to identifying an overpayment, the Authority or designee may contact the provider for the purpose of providing preliminary information and requesting additional documentation. provider must provide the requested documentation within the time frames requested.

(7) When an overpayment is identified, Authority will notify the provider in writing, as to the nature of the discrepancy, the method of computing the dollar amount of the overpayment, and any further action that the Authority may take in the matter:

(a) The Authority notice may require the provider to submit applicable documentation for review prior to requesting an appeal from the Authority, and may impose reasonable time limits for when such documentation must be provided in order to be considered by the Authority.

(b) The provider may appeal a Authority notice of overpayment in the manner provided in OAR 410-120-1560.

(8) The Authority may recover overpayments made to a provider by direct reimbursement, offset, civil action, or other actions authorized by law:

(a) The provider must make a direct reimbursement to the Authority within thirty (30) calendar days from the date of the notice of the overpayment, unless other regulations apply;

(b) The Authority may grant the provider an additional period of time to reimburse the Authority upon written request made within thirty (30) calendar days from the date of the notice of overpayment if the provider provides a statement of facts and reasons sufficient to show that repayment of the overpayment amount should be delayed pending appeal because:

(i) The provider will suffer irreparable injury if the overpayment repayment is not delayed;

(ii) There is a plausible reason to believe that the overpayment is not correct or is less than the amount in the notice, and the provider has timely filed an appeal of the overpayment, or that provider accepts the amount of the overpayment but is requesting to make repayment over a period of time;

(iii) A proposed method for assuring that the amount of the overpayment can be repaid when due with interest, including but not limited to a bond, irrevocable letter of credit or other undertaking, or a repayment plan for making payments including interest over a period of time.

(iv) Granting the delay will not result in substantial public harm;

(v) Affidavits containing evidence relied upon in support of the request for stay:

(vi) The Authority may consider all information in the record of the overpayment determination, including provider cooperation with timely provision of documentation, in addition to the information supplied in provider's request. If provider requests a repayment plan, the Authority may require conditions acceptable to the Authority before agreeing to a repayment plan. The Authority must issue an order granting or denying a repayment delay request within thirty (30) calendar days after receiving it.

(c) Except as otherwise provided in subsection (b) a request for a hearing or administrative review does not change the date the repayment of the overpayment is due, and if the outcome of the appeal reduces the amount of the overpayment, that amount previously paid by the provider in response to the notice of overpayment will be refunded to the provider;

(d) The Authority may withhold payment on pending claims and on subsequently received claims for the amount of the overpayment when overpayments are not paid as a result of Section (7)(a);

(e) The Authority may file a civil action in the appropriate court and exercise all other civil remedies available to the Authority in order to recover the amount of an overpayment.

(9) In addition to any overpayment, the Authority may impose a sanction on the provider in connection with the actions that resulted in the overpayment. The Authority may, at its discretion, combine a notice of sanction with a notice of overpayment.

(10) Voluntary submission of an Individual Adjustment Request or overpayment amount after notice from the Authority does not prevent the Authority from issuing a notice of sanction, but the Authority may take such voluntary payment into account in determining the sanction.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.105, 414.106, 414.805

410-120-1400 – Provider Sanctions

(1) The Oregon Health Authority (Authority) recognizes two classes of provider sanctions, mandatory and discretionary, outlined in (3) and (4) respectively.

(2) Except as otherwise noted, the Authority will impose provider sanctions at the discretion of the Authority Director or the Administrator of the Division whose budget includes payment for the services involved.

(3) The Division of Medical Assistance Programs (Division) will impose mandatory sanctions and suspend the provider from participation in Oregon's medical assistance programs:

(a) When a provider of medical services has been convicted (as that term is defined in 42 CFR 1001.2) of a felony or misdemeanor related to a crime, or violation of Title XVIII, XIX, or XX of the Social Security Act or related state laws;

(b) When a provider is excluded from participation in federal or state health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services or from the Medicare (Title XVIII) program of the Social Security Act as determined by the Secretary of Health and Human Services. The provider will be excluded and suspended from participation with the Division for the duration of exclusion or suspension from the Medicare program or by the Office of the Inspector General;

(c) If the provider fails to disclose ownership or control information required under 42 CFR 455.104 that is required to be reported at the time the provider submits a provider enrollment application or when there is a material change in the information that must be reported, or information related to business transactions required to be provided under 42 CFR 455.105 upon request of federal or state authorities.

(4) The Division may impose discretionary sanctions when the Division determines that the provider fails to meet one or more of the Division’s requirements governing participation in its medical assistance programs. Conditions that may result in a discretionary sanction include, but are not limited to, when a provider has:

(a) Been convicted of fraud related to any federal, state, or locally financed health care program or committed fraud, received kickbacks, or committed other acts that are subject to criminal or civil penalties under the Medicare or Medicaid statutes;

(b) Been convicted of interfering with the investigation of health care fraud;

(c) Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(d) By actions of any state licensing authority for reasons relating to the provider's professional competence, professional conduct, or financial integrity either:

(A) Had his or her health care license suspended or revoked, or has otherwise lost such license; or

(B) Surrendered his or her license while a formal disciplinary proceeding is pending before such licensing authority.

(e) Been suspended or excluded from participation in any federal or state health care program for reasons related to professional competence, professional performance, or other reason;

(f) Billed excessive charges (i.e., charges in excess of the usual charge); furnished items or services substantially in excess of the Division client's needs or in excess of those services ordered by a medical provider or in excess of generally accepted standards or of a quality that fails to meet professionally recognized standards;

(g) Failed to furnish medically necessary services as required by law or contract with the Division if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the Division client;

(h) Failed to disclose required ownership information;

(i) Failed to supply requested information on subcontractors and suppliers of goods or services;

(j) Failed to supply requested payment information;

(k) Failed to grant access or to furnish as requested, records, or grant access to facilities upon request of the Division or the State of Oregon's Medicaid Fraud Unit conducting their regulatory or statutory functions;

(l) In the case of a Hospital, failed to take corrective action as required by the Division, based on information supplied by the Quality Improvement Organization to prevent or correct inappropriate admissions or practice patterns, within the time specified by the Division;

(m) Defaulted on repayment of federal or state government scholarship obligations or loans in connection with the provider's health profession education. The Division:

(A) Must have made a reasonable effort to secure payment;

(B) Must take into account access of beneficiaries to services; and

(C) Will not exclude a community's sole physician or source of essential specialized services.

(n) Repeatedly submitted a claim with required data missing or incorrect:

(A) When the missing or incorrect data has allowed the provider to:

(i) Obtain greater payment than is appropriate;

(ii) Circumvent prior authorization requirements;

(iii) Charge more than the provider's usual charge to the general public;

(iv) Receive payments for services provided to persons who were not eligible;

(v) Establish multiple claims using procedure codes that overstate or misrepresent the level, amount or type of health care provided.

(B) Does not comply with the requirements of OAR 410-120-1280.

(o) Failed to develop, maintain, and retain in accordance with relevant rules and standards adequate clinical or other records that document the medical appropriateness, nature, and extent of the health care provided;

(p) Failed to develop, maintain, and retain in accordance with relevant rules and standards adequate financial records that document charges incurred by a client and payments received from any source;

(q) Failed to develop, maintain and retain adequate financial or other records that support information submitted on a cost report;

(r) Failed to follow generally accepted accounting principles or accounting standards or cost principles required by federal or state laws, rules, or regulations;

(s) Submitted claims or written orders contrary to generally accepted standards of medical practice;

(t) Submitted claims for services that exceed that requested or agreed to by the client or the responsible relative or guardian or requested by another medical provider;

(u) Breached the terms of the provider contract or agreement. This includes failure to comply with the terms of the provider certifications on the medical claim form;

(v) Rebated or accepted a fee or portion of a fee or charge for a Division client referral; or collected a portion of a service fee from the client, and billed the Division for the same service;

(w) Submitted false or fraudulent information when applying for a Division-assigned provider number, or failed to disclose information requested on the provider enrollment application;

(x) Failed to correct deficiencies in operations after receiving written notice of the deficiencies from the Division;

(y) Submitted any claim for payment for which payment has already been made by the Division or any other source unless the amount of the payment from the other source is clearly identified;

(z) Threatened, intimidated or harassed clients or their relatives in an attempt to influence payment rates or affect the outcome of disputes between the provider and the Division;

(aa) Failed to properly account for a Division client's Personal Incidental Funds; including but not limited to using a client's Personal Incidental Funds for payment of services which are included in a medical facility's all-inclusive rates;

(bb) Provided or billed for services provided by ineligible or unsupervised staff;

(cc) Participated in collusion that resulted in an inappropriate money flow between the parties involved, for example, referring clients unnecessarily to another provider;

(dd) Refused or failed to repay, in accordance with an accepted schedule, an overpayment established by the Division;

(ee) Failed to report to Division payments received from any other source after the Division has made payment for the service;

(ff) Collected or made repeated attempts to collect payment from clients for services covered by the Division, per OAR 410-120-1280, Billing.

(5) A provider who has been excluded, suspended or terminated from participation in a federal or state medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, shall not submit claims for payment, either personally or through claims submitted by any billing agent/service, billing provider or other provider, for any services or supplies provided under the medical assistance programs, except those services or supplies provided prior to the date of exclusion, suspension or termination.

(6) providers must not submit claims for payment to the Division for any services or supplies provided by a person or provider entity that has been excluded, suspended or terminated from participation in a federal or state medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, except for those services or supplies provided prior to the date of exclusion, suspension or termination.

(7) When the provisions of subsections (5) or (6) are violated, the Division may suspend or terminate the billing provider or any individual performing provider within said organization who is responsible for the violation(s).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025 & 414.065

410-120-1460 – Type and Conditions of Sanction

(1) The Division of Medical Assistance Programs (Division) may impose mandatory sanctions on a provider pursuant to OAR 410-120-1400(3), in which case:

(a) The provider will be either terminated or suspended from participation in Oregon's medical assistance programs;

(b) If suspended, the minimum duration of suspension will be determined by the Secretary of the Department of Health and Human Services (DHHS), under the provisions of 42 CFR Parts 420, 455, 1001, or 1002. The State may suspend a provider from participation in Oregon's medical assistance programs longer than the minimum suspension determined by the DHHS Secretary.

(2) The Division may impose the following discretionary sanctions on a provider pursuant to OAR 410-120-1400(4):

(a) The provider may be terminated from participation in Oregon's medical assistance programs;

(b) The provider may be suspended from participation in Oregon's medical assistance programs for a specified length of time, or until specified conditions for reinstatement are met and approved by the Division;

(c) The Division may withhold payments to a provider;

(d) The provider may be required to attend provider education sessions at the expense of the sanctioned provider;

(e) The Division may require that payment for certain services are made only after the Division has reviewed documentation supporting the services;

(f) The Division may recover investigative and legal costs;

(g) The Division may provide for reduction of any amount otherwise due the provider; and the reduction may be up to three times the amount a provider sought to collect from a client in violation of OAR 410-120-1280;

(h) Any other sanctions reasonably designed to remedy or compel future compliances with federal, state or Division regulations.

(3) The Division will consider the following factors in determining the sanction(s) to be imposed (this list includes but is not limited to these factors):

(a) Seriousness of the offense(s);

(b) Extent of violations by the provider;

(c) History of prior violations by the provider;

(d) Prior imposition of sanctions;

(e) Prior provider education;

(f) Provider willingness to comply with program rules;

(g) Actions taken or recommended by licensing boards or a Quality Improvement Organization (QIO); and

(h) Adverse impact on the health of Division clients living in the provider's service area.

(4) When a provider fails to meet one or more of the requirements identified in this rule Division, at its sole discretion, may immediately suspend the provider's Division-assigned billing number to prevent public harm or inappropriate expenditure of public funds:

(a) The provider subject to immediate suspension is entitled to a contested case hearing as outlined in 410-120-1600 through 410-120-1700 to determine whether the provider's Division-assigned number will be revoked;

(b) The notice requirements described in section (5) of this rule do not preclude immediate suspension at the Division’s sole discretion to prevent public harm or inappropriate expenditure of public funds. Suspension may be invoked immediately while the notice and contested case hearing rights are exercised.

(5) If the Division decides to sanction a provider, the Division will notify the provider by certified mail or personal delivery service of the intent to sanction. The notice of immediate or proposed sanction will identify:

(a) The factual basis used to determine the alleged deficiencies;

(b) Explanation of actions expected of the provider;

(c) Explanation of subsequent actions the Division intends to take;

(d) The provider's right to dispute the Division’s allegations, and submit evidence to support the provider's position; and

(e) The provider's right to appeal the Division’s proposed actions pursuant to OARs 410-120-1560 through 410-120-1700.

(6) If the Division makes a final decision to sanction a provider, the Division will notify the provider in writing at least 15 days before the effective date of action, except in the case of immediate suspension to avoid public harm or inappropriate expenditure of funds.

(7) The provider may appeal the Division's immediate or proposed sanction(s) or other action(s) the Division intends to take, including but not limited to the following list. The provider must appeal these actions separately from any appeal of audit findings and overpayments:

(a) Termination or suspension from participation in the Medicaid-funded medical assistance programs;

(b) Termination or suspension from participation in the Division's state-funded programs;

(c) Revocation of the provider's Division-assigned provider number.

(8) Other provisions:

(a) When a provider has been sanctioned, all other provider entities in which the provider has ownership (five percent or greater) or control of, may also be sanctioned;

(b) When a provider has been sanctioned the Division may notify the applicable professional society, board of registration or licensure, federal or state agencies, Oregon Health Plan Prepaid Health Plans and the National Practitioner Data Base of the findings and the sanctions imposed;

(c) At the discretion of the Division, providers who have previously been terminated or suspended may or may not be re-enrolled as Division providers;

(d) Nothing in this rule prevents the Division from simultaneously seeking monetary recovery and imposing sanctions against the provider;

(e) If the Division discovers continued improper billing practices from a provider who, after having been previously warned in writing by the Division or the Department of Justice about improper billing practices and has had an opportunity for a contested case hearing, that provider will be liable to the Division for up to triple the amount of the Division's established overpayment received as a result of such violation.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025 & 414.065

410-120-1510 – Fraud and Abuse

(1) This rule sets forth requirements for reporting, detecting and investigating fraud and abuse. The terms fraud and abuse in this rule are defined in OAR 410-120-0000. As used in these rules, terms have the following meanings:

(a) “Credible allegation of fraud” means an allegation of fraud, which has been verified by the State and has indicia of reliability that comes from any source as defined in 42 CFR 455.2.

(b) "Conviction" or "convicted" means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending;

(c) "Exclusion" means that the Oregon Health Authority (Authority) or the Department of Human Services (Department) will not reimburse a specific provider who has defrauded or abused Authority or Department for items or services that provider furnished;

(d) "Prohibited kickback relationships" means remuneration or payment practices that may result in federal civil penalties or exclusion for violation of 42 CFR 1001.951;

(e) "Suspension" means the Authority or Department will not reimburse a specified provider who has been convicted of a program-related offense in a federal, state or local court for items or services that provider furnished.

(2) Cases involving one or more of the following situations shall constitute sufficient grounds for a provider fraud referral:

(a) Billing for services, supplies, or equipment that are not rendered to, or used for, Medicaid patients;

(b) Billing for supplies or equipment that are clearly unsuitable for the patient's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless;

(c) Claiming costs for non-covered or non-chargeable services, supplies, or equipment disguised as covered items;

(d) Materially misrepresenting dates and descriptions of services rendered, the identity of the individual who rendered the services, or of the recipient of the services;

(e) Duplicate billing of the Medicaid Program or of the recipient, that appears to be a deliberate attempt to obtain additional reimbursement; and

(f) Arrangements by providers with employees, independent contractors, suppliers, and other, and various devices such as commissions and fee splitting, that appear to be designed primarily to obtain or conceal illegal payments or additional reimbursement from Medicaid.

(2) Provider is required to promptly refer all suspected fraud and abuse, including fraud or abuse by its employees or in the Division administration, to the Medicaid Fraud Control Unit (MFCU) of the Department of Justice or to the Department of Human Services (Department) Provider Audit Unit (PAU). For contact information, see the General Rules Supplemental Information Guide online at www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html.

(3) Provider, if aware of suspected fraud or abuse by an Authority or Department client (i.e., provider reporting Authority or Department client fraud and abuse) must report the incident to the Department Fraud Investigations Unit (FIU). For contact information, see the General Rules Supplemental Information Guide online at www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html.

(4) Provider shall permit the MFCU, Authority or Department, or other law enforcement entity, together or separately to inspect, copy, evaluate or audit books, records, documents, files, accounts, and facilities, without charge, as required to investigate an incident of fraud or abuse. When a provider fails to provide immediate access to records, Medicaid payments may be withheld or suspended.

(5) Providers and their fiscal agents must disclose ownership and control information, and disclose information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid or the Title XX services program. Such disclosure and reporting is made a part of the provider enrollment agreement, and the provider is obligated to update that information with an amended provider enrollment agreement if any of the information materially changes. The Authority or Department shall use that information to meet the requirements of 42 CFR 455.100 to 455.106, and this rule must be construed in a manner that is consistent with the Authority or Department acting in compliance with those requirements.

(6) The Authority or Department may share information for health oversight purposes with the MFCU and other federal or state health oversight authorities.

(7) The Authority or Department may suspend payments in whole or part in a suspected case of fraud or abuse, or where there exists a credible allegation of fraud or abuse presented to the Authority, the Department or other law enforcement entity, or where there is a pending investigation or conclusion of legal proceedings related to the provider's alleged fraud or abuse.

(8) The Authority or Department is authorized to take the actions necessary to investigate and respond to credible allegations of Fraud and Abuse, including but not limited to suspending or terminating the provider from participation in the medical

assistance programs, withholding payments or seeking recovery of payments made to the provider, or imposing other Sanctions provided under state law or regulations. Such actions by the Authority or Department may be reported to the Centers for Medicare and Medicaid Services, or other federal or state entities as appropriate.

(9) The Authority or Department will not pay for covered services provided by persons who are currently suspended, debarred or otherwise excluded from participating in Medicaid, Medicare, or CHIP, or who have been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, XXI or XX of the Social Security Act or related laws.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025 & 414.065

410-120-1560 – Provider Appeals

(1) For purposes of Division of Medical Assistance Programs (Division) provider appeal rules in chapter 410, division 120 the following terms and definitions are used:

(a) “Provider” means a person or entity enrolled with the Division, or under contract with the Division that is subject to the Division rules, that has requested an appeal in relation to health care, items, drugs or services provided or requested to be provided to a client on a fee-for-service basis or under contract with the Division where that contract expressly incorporates these rules;

(b) “Provider Applicant” means a person or entity that has submitted an application to become an enrolled provider with the Division but the application has not been approved;

(c) “Prepaid Health Plan” has the meaning in OAR 410-141-0000, except to the extent that Mental Health Organizations (MHO) have separate procedures applicable to provider grievances and appeals;

(d) “Prepaid Health Plan provider” means a person or entity enrolled with the Division but that provided health care services, supplies or items to a client enrolled with a PHP, including both participating providers and non-participating providers as those terms are defined in OAR 410-141-0000, except that services provided to a client enrolled with an MHO shall be governed by the provider grievance and appeal procedures administered by the Office of Mental Health and Addiction Services;

(e) The “Provider Appeal Rules” refers to the rules in OAR 410-120-1560 to 410-120-1700, describing the availability of appeal procedures and the procedures applicable to each appeal procedure;

(f) “Non-participating provider” has the meaning in OAR 410-141-0000;

(g) Coordinated Care Organization (CCO) has the meaning in OAR 410-141-0000,

(2) A Division of Medical Assistance Programs (Division) enrolled provider may appeal a Division decision in which the provider is directly adversely affected such as the following:

(a) A denial or limitation of payment allowed for services or items provided;

(b) A denial related to a NCCI edit;

(c) A denial of provider’s application for new or continued participation in the Medical Assistance Program; or

(d) Sanctions imposed, or intended to be imposed, by the Medical Assistance program on a provider or provider entity; and

(e) Division overpayment determinations made under OAR 410-120-1397.

(3) Client appeals of actions must be handled in accordance with OAR 140-120-1860 and 410-120-1865.

(4) A provider appeal is initiated by filing a timely request in writing for review with the Division.

(a) A provider appeal request is not required to follow a specific format as long as it provides a clear written expression from a provider or provider applicant expressing disagreement with a Division decision or from a CCO or PHP provider expressing disagreement with a decision by a CCO or PHP.

(b) The request should identify the decision made by the Division or a CCO or PHP that is being appealed and the reason the provider disagrees with that decision.

(c) A provider appeal request is timely if it is received by the Division within 180 calendar days of the date of the Division's decision or 30 calendar days of the date of the CCO or PHP decision on the provider's appeal to the CCO or PHP.

(5) Types and methods for provider appeals are listed below.

(a) A Division of Medical Assistance Programs (Division) denial of or limitation of payment allowed, Division claim decision including prior authorization decision, or Division overpayment determination for services or items provided to a client must be appealed as claim re-determinations under OAR 410-120-1570.

(b) A notice of sanctions imposed, or intended to be imposed, the effect of the notice of sanction is, or will be, to deny suspend or revoke a provider number necessary to participate in the medical assistance on a provider, or provider applicant is entitled to appeal under OAR 410-120-1600. A provider that is entitled to appeal a notice of sanction as a contested case may request administrative review instead of contested case hearing if the provider submits a written request for administrative review of the notice of sanction and agrees in writing to waive the right to a contested case hearing and the Division agrees to review the appeal of the notice of sanction as an administrative review.

(c) All provider appeals of Division decisions not described in paragraphs (4)(a) or (b) are handled as administrative reviews in accordance with OAR 410-120-1580, unless Division issues an order granting a contested case hearing.

(6) Decisions that adversely affect a provider may be made by different program areas within the Authority.

(a) Decisions issued by the Office of Payment Accuracy and Recovery (OPAR) or the Authority information security office shall be appealed in accordance with the process described in the notice,

(b) Other program areas within the Authority that have responsibility for administering medical assistance funding, such as nursing home care or community mental health and developmental disabilities program services, may make decisions that adversely affect a provider. Those providers are subject to the provider grievance or appeal processes applicable to those payment or program areas.

(c) Some decisions that adversely affect a provider are issued on behalf of the Division by Authority contractors such as the Division pharmacy benefits manager, by entities performing statutory functions related to the medical assistance programs such as the Drug Use Review Board, or by other entities in the conduct of program integrity activities applicable to the administration of the medical assistance programs. For these decisions made on behalf of the division in which the Division has legal authority to make the final decision in the matter, a provider may appeal such a decision to the Division as an administrative review and the Division may accept such review.

(d) This rule does not apply to contract administration issues that may arise solely between the Division and a CCO or PHP. Such issues shall be governed by the terms of the applicable contract.

(e) The Division provides limited provider appeals for CCO or PHP providers or non-participating providers concerning a decision by a CCO orPHP. In general, the relationship between a CCO or PHP and their providers is a contract matter between them. Client appeals are handled under the client appeal rules, not provider appeal rules.

(i) The CCO or PHP provider seeking a provider appeal must have a current valid provider enrollment agreement with the Division and, unless the provider is a non-participating provider, must also have a contract with the CCO or PHP as a CCO or PHP provider; and

(ii) The CCO or PHP provider or non-participating provider must have exhausted the applicable appeal procedure established by the CCO or PHP and the request for provider appeal must include a copy of the written decision(s) of the CCO or PHP that is being appealed from and a copy of any CCO or PHP policy being applied in the appeal; and

(iii) The CCO or PHP provider appeal or non-participating provider appeal from a CCO or PHP decision is limited to issues related to the scope of coverage and authorization of services under the Oregon Health Plan, including whether services are included as covered on the Prioritized List, guidelines, and in the OHP Benefit package. The Division provider appeal process does not include

CCO or PHP payment or claims reimbursement amount issues, except in relation to non-participating provider matters governed by Division rule.

(iv) A timely provider appeal must be made within 30 calendar days from the date of the CCO or PHP's decision and include evidence that the PHP was sent a copy of the provider appeal. In every provider appeal involving a CCO or PHP decision, the CCO or PHP will be treated as a participant in the appeal.

(7) In the event a request for provider appeal is not timely, the Division will determine whether the failure to file the request was caused by circumstances beyond the control of the provider, provider applicant or CCO or PHP provider. In determining whether to accept a late request for review, the Division requires the request to be supported by a written statement that explains why the request for review is late. The Division may conduct such further inquiry as the Division deems appropriate. In determining timeliness of filing a request for review, the amount of time that the Division determines accounts for circumstances beyond the control of the provider is not counted. The Division may refer an untimely request to the Office of Administrative Hearings for a hearing on the question of timeliness.

(8) The burden of presenting evidence to support a provider appeal is on the provider, provider applicant CCO or PHP provider.

(a) Consistent with OAR 410-120-1360, payment on a claim will only be made for services that are adequately documented and billed in accordance with OAR 410-120-1280 and all applicable administrative rules related to covered services for the client's benefit package and establishing the conditions under which services, supplies or items are covered, such as the Prioritized List, medical appropriateness and other applicable standards.

(b) Eligibility for enrollment and for continued enrollment is based on compliance with applicable rules, the information submitted or required to be submitted with the application for enrollment and the enrollment agreement, and the documentation required to be produced or maintained in accordance with OAR 410-120-1360.

(9) Provider appeal proceedings, if any, will be held in Salem, unless otherwise stipulated to by all parties and agreed to by the Division.

Stat. Auth.: ORS 413.042& 414.065

Stats. Implemented: ORS 414.025 & 414.065

410-120-1570 – Claim Re-Determinations

(1) If a provider disagrees with an initial claim determination made by the Division of Medical Assistance Program (Division), the provider may request a review for re-determination of the denied claim payment.

(2) This rule does not apply to determinations that:

(a) Result in a “Notice of Action” that must be provided to the OHP client. If the decision under review requires any notice to the OHP client under applicable rules (OAR 410-120-1860, 410-414-0263), the procedures for notices and hearings must be followed; or

(b) Are made by a CCO or PHP regarding services to a CCO or PHP member. The provider must contact the CCO or PHP in accordance with 410-120-1560.

(3) How to request a redetermination review:

(a) To request a review, the provider must submit a written request to the Division Provider Services Unit within 180 days of the original claim adjudication date.

(b) The written request must include all information needed to adjudicate the claim or support changing the original claim determination, including but not limited to:

(A) A detailed letter of explanation identifying the specific re-determination denial issue and/or alleged error; .

(B) All relevant medical records and evidence-based practice data to support the position being asserted on review;

(C) The specific service, supply or item being denied, including all relevant codes;

(D)Detailed justification for the re-determination of the denied service; and

(E) A copy of the original claim and a copy of the original denial notice or remittance advice that describes the basis for the claim denial under re-determination;

(F) Any information and/or medical documentation pertinent to support the request and to obtain a resolution of the re-determination review dispute.

(4) A provider requesting a re-determination review must demonstrate one or more of the following reasons that would allow coverage in the particular case:

(a) A below-the-line condition/treatment pair is justified under the co-morbid rule OAR 410-141-0480(8);

(b) A treatment that is part of a covered complex procedure and/or related to an existing funded condition;

(c) A service not listed on the HSC Prioritized List that may be covered under OAR 410-141-0480(10);

(d) A service that satisfies the Citizen/Alien-Waived Emergency Medical (CAWEM) emergency service criteria;

(e) Medical documentation of applicable evidence-based practice literature that is consistent with the condition or service under review;

(f) A service that satisfies the prudent layperson definition of emergency medical condition;

(g) A service intended to prolong survival or palliate symptoms, due to expected length of life consistent with the HSC Statement of Intent for Comfort/Palliative Care;

(h) A service that should be covered where denial was due to technical errors and omissions with the Oregon Health Services Commission's (HSC) Prioritized List of approved Health Services

(i) Misapplication of a fee schedule;

(j) A denied duplicate claim that the provider believes were incorrectly identified as a duplicate;

(k) Incorrect data items, such as provider number, use of a modifier or date of service, unit changes or incorrect charges;

(l) Errors with the Medicaid Management Information System (MMIS), such as a code is missing in MMIS that the Oregon Health Services Commission (HSC) has placed on the Prioritized List of Health Services;

(m) Services provided without the required prior-authorization, except for those authorizations subject to provision outlined in OAR 410-120-1280(2)(a)(C);

(n) A covered diagnostic service.

(5) The Division will review all re-determination requests as follows:

(a) The review is based on the Division review of supplied documentation and applicable law(s);

(b) The Division may request additional information from the provider that it finds relevant to the request under review;

(c) The Division does not provide a face-to-face meeting with providers as part of the re-determination review process.

(d) The Division will notify a provider requesting review that the re-determination request has been denied if:

(A) The provider did not submit a timely request;

(B) The required information is not provided at the same time the request is submitted; and/or

(C) The provider fails to submit any additional requested information within 14 business days of request.

(7) The Division's final decision under this rule is the final decision on appeal. Under ORS 183.484, this decision is an order in other than a contested case. ORS 183.484 and the procedures in OAR 137-004-0080 to 137-004-0092 apply to the Division's final decision under this rule.

Stat. Auth.: ORS.413.042

Stat. Implemented: 414.065

410-120-1580 – Provider Appeals - Administrative Review

(1) An administrative review is a provider appeal process that allows an opportunity for the Administrator of the Division of Medical Assistance Programs (Division) or designee to review a Division decision affecting the provider, provider applicant, Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) provider, where administrative review is appropriate and consistent with these provider appeal rules OAR 410-120-1560.

(2) Administrative review is an appeal process under OAR 410-120-1560 that addresses primarily legal or policy issues that may arise in the context of a Division decision that adversely affects the Provider and that is not otherwise reviewed as a claim re-determination, a contested case, or client appeal.

(a) If the Division finds that the appeal should be handled as a different form of provider appeal or as a client appeal, the Administrator or designee will notify the provider of this determination.

(b) Within the time limits established by the Division in the administrative review, the provider, provider applicant, CCO or PHP provider must provide Division (and CCO or PHP, if applicable) with a copy of all relevant records, the Division, CCO or PHP decisions, and other materials relevant to the appeal.

(3) If the Administrator or designee decides that a meeting between the provider, provider applicant, CCO or PHP Provider (and CCO or PHP, if applicable) and the Division staff will assist the review, the Administrator or designee will:

(a) Notify the provider requesting the review of the date, time, and place the meeting is scheduled;

(b) Notify the CCO or PHP (when client is enrolled in a CCO or PHP) of the date, time, and place the meeting is scheduled. The CCO or PHP is not required to participate, but is invited to participate in the process.

(4) The review meeting will be conducted in the following manner:

(a) It will be conducted by the Division Administrator, or designee;

(b) No minutes or transcript of the review will be made;

(c) The provider requesting the review does not have to be represented by counsel during an administrative review meeting and will be given ample opportunity to present relevant information;

(d) The Division staff will not be available for cross-examination, but the Division staff may attend and participate in the review meeting;

(e) Failure to appear without good cause constitutes acceptance of the Division's determination;

(f) The Administrator may combine similar administrative review proceedings, including the meeting, if the Administrator determines that joint proceedings may facilitate the review;

(g) The Division Administrator or designee may request the provider, provider Applicant, CCO or PHP Provider making the appeal to submit, in writing, new information that has been presented orally. In such an instance, a specific date for receiving such information will be established.

(5) The results of the administrative review will be sent to the participants, involved in the review, and to the CCO or PHP when review involved a CCO or PHP provider, in writing, within 30 calendar days of the conclusion of the administrative review proceeding, or such time as may be agreed to by the participants and the Division.

(6) The department's final decision on administrative review is the final decision on appeal and binding on the parties. Under ORS 183.484, this decision is an order in other than a contested case. ORS 183.484 and the procedures in OAR 137-004-0080 to 137-004-0092 apply to the department's final decision on administrative review.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-120-1600 – Provider Appeals — Contested Case Hearings

(1) A contested case procedure is a hearing that is conducted by the Office of Administrative Hearings where a contested case is appropriate and consistent with the provider appeal rules OAR 410-120-1560. If the request for contested case hearing was timely filed but should have been filed as a claim redetermination or administrative review, or client appeal, Division will refer the request to the proper appeal procedure and notify the Provider, provider applicant, CCO or PHP provider.

(2) Contested case hearings are conducted in accordance with the Attorney General's model rules at OAR 137-003-0501 to 137-003-0700.

(3) The party to a provider contested case hearing is the provider, provider applicant, CCO or PHP provider who requested the appeal. In the event that Division determines that a CCO or PHP provider is entitled to a Contested Case Hearing under OAR 410-120-1560, the CCO or PHP Provider and the CCO or PHP are parties to the hearing. A provider, CCO or PHP provider, CCO or PHP that is a corporation may be represented by any of the persons identified in ORS 410.190.

(4) Informal conference: Division may notify the provider(s) provider applicant, CCO or PHP provider (and CCO or PHP, if applicable) of the time and place of an informal conference, without the presence of the Administrative Law Judge (ALJ). The purposes of this informal conference are:

(a) To provide an opportunity to settle the matter;

(b) To make sure the parties and the Authority understand the specific reason for the action of the hearing request;

(c) To give the parties and the Authority an opportunity to review the information which is the basis for action;

(d) To give the parties and the Authority the chance to correct any misunderstanding of the facts; and

(e) The provider, provider applicant, CCO or PHP provider (or CCO, PHP, if applicable) may, at any time prior to the hearing date, request an additional informal conference with the Division and Authority representative(s), which may be granted if the Division finds at its sole discretion, the additional informal conference will facilitate the Contested Case Hearing process or resolution of disputed issues.

(5) Contested Case Hearing: The Administrative Law Judge (ALJ) will conduct the contested case hearing using the Attorney General's Model Rules at OAR 137-003-0501 to 137-003-0700.

(a) The burden of presenting evidence to support a provider appeal is on the provider, provider applicant, CCO or PHP provider that requested the appeal. Consistent with OAR 410-120-1360, payment on a claim will only be made for services that are adequately documented and billed in accordance with OAR 410-120-1280 and all applicable administrative rules related to covered services for the Client's benefit package and establishing the conditions under which services, supplies or items are covered, such as the Prioritized List, medical appropriateness and other applicable standards.

(b) Subject to Division approval under OAR 137-003-0525, the ALJ will determine the location of the Contested Case Hearings.

(6) Proposed and Final Orders: The ALJ is authorized to serve a proposed order on all parties and the Division unless prior to the hearing, the Division notifies the ALJ that a final order may be served by the ALJ.

(a) If the ALJ issues a proposed order, and the proposed order is adverse to a party, the party may file written exceptions to the proposed order to be considered by the Division, or the ALJ when the ALJ is authorized to issue the final order. The exceptions must be in writing and received by the Division, or the ALJ when the ALJ is authorized to issue the final order, not later than 10 calendar days after the date of the proposed order is issued by the ALJ. No additional evidence may be submitted without prior approval of Division.

(b) The proposed order issued by the ALJ will become a final order if no exceptions are filed within the time specified in subsection (a) of this rule, unless the Division notifies the parties and the ALJ that Division will issue the final order. After receiving the exceptions or argument, if any, the Division may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, Division may issue an amended proposed order.

(c) Procedures applicable to default orders for withdrawal of a hearing request, failure to timely request a hearing, failure to appear at a hearing, or other default, are governed by the Attorney General's Model Rules, OAR 137-003-0670 – 137-003-0672.

(d) The final order is effective immediately upon being signed or as otherwise provided in the order.

(7) All Contested Case Hearing decisions are subject to the procedures established in OAR 137-003-675 to 137-003-0700 and to judicial review under ORS 183.482 in the Court of Appeals.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-120-1855 – Client's Rights and Responsibilities

(1) Division of Medical Assistance Programs (Division) clients shall have the following rights:

(a) To be treated with dignity and respect;

(b) To be treated by providers the same as other people seeking health care benefits to which they are entitled;

(c) To refer oneself directly to mental health, substance use disorder or family planning services without getting a referral from a Primary Care Practitioner (PCP) or other provider;

(d) To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines;

(e) To be actively involved in the development of his/her treatment plan;

(f) To be given information about his/her condition and covered and non-covered services to allow an informed decision about proposed treatment(s);

(g) To consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services;

(h) To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

(i) To have written materials explained in a manner that is understandable to the Division client;

(j) To receive necessary and reasonable services to diagnose the presenting condition;

(k) To receive Division covered services that meet generally accepted standards of practice and are medically appropriate;

(l) To obtain covered preventive services;

(m) To receive a referral to specialty providers for medically appropriate covered services;

(n) To have a clinical record maintained which documents conditions, services received, and referrals made;

(o) To have access to one's own clinical record, unless restricted by statute;

(p) To transfer of a copy of his/her clinical record to another provider;

(q) To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, substance use disorder or mental health treatment and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990 -- Patient Self-Determination Act;

(r) To receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations;

(s) To know how to make a Complaint, Grievance or Appeal with the Division and receive a response as defined in OAR 410-120-1860 and 410120-1865;

(t) To request an Administrative Hearing with the Oregon Health Authority (Authority);

(u) To receive a notice of an appointment cancellation in a timely manner;

(v) To receive adequate notice of Authority privacy practices.

(2) Division clients shall have the following responsibilities:

(a) To treat the providers and clinic's staff with respect;

(b) To be on time for appointments made with providers and to call in advance either to cancel if unable to keep the appointment or if he/she expects to be late;

(c) To seek periodic health exams and preventive services from his/her PCP or clinic;

(d) To use his/her PCP or clinic for diagnostic and other care except in an Emergency;

(e) To obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;

(f) To use emergency services appropriately;

(g) To give accurate information for inclusion in the clinical record;

(h) To help the provider or clinic obtain clinical records from other providers which may include signing an authorization for release of information;

(i) To ask questions about conditions, treatments and other issues related to his/her care that is not understood;

(j) To use information to make informed decisions about treatment before it is given;

(k) To help in the creation of a treatment plan with the provider;

(l) To follow prescribed agreed upon treatment plans;

(m) To tell the provider that his or her health care is covered with the Division before services are received and, if requested, to show the provider the OMAP Medical Care Identification form;

(n) To tell the Department worker of a change of address or phone number;

(o) To tell the Department worker if the Division client becomes pregnant and to notify the Department worker of the birth of the Division client's child;

(p) To tell the Department worker if any family members move in or out of the household;

(q) To tell the Department worker and provider(s) if there is any other insurance available, changes of insurance coverage including Private Health Insurance (PHI) according to OAR 410-120-1960, and to complete required periodic documentation of such insurance coverage in a timely manner;

(r) To pay for non-Covered Services under the provisions described in OAR 410-120-1200 and 410-120-1280;

(s) To pay the monthly OHP premium on time if so required;

(t) To assist the Division in pursuing any TPR available and to pay the Division the amount of benefits it paid for an injury from any recovery received from that injury;

(u) To bring issues, or Complaints or Grievances to the attention of the Division; and

(v) To sign an authorization for release of medical information so that the Authority can get information which is pertinent and needed to respond to an Administrative Hearing request in an effective and efficient manner.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

410-120-1860 – Contested Case Hearing Procedures

(1) These rules apply to all contested case hearings provided by the Division of Medical Assistance Programs (Division) involving a client's health care benefits, except as otherwise provided in OAR 410-141-0263. The hearings are conducted in accordance with the Attorney General's model rules at 137-003-0501 and following. When the term "agency" is used in the Attorney General's model rules, it shall refer to the Division for purposes of this rule Except for 137-003-0528(1)(a), the method described in 137-003-0520(8)-(10) is used in computing any period of time prescribed in this division of rules (OAR 410 division 120) applicable to timely filing of client requests for hearing. Due to operational conflicts, the procedures needing revision and the expense of doing so, 137-003-0528(1)(a), which allows hearing requests to be treated as timely based on the date of postmark, does not apply to Division contested cases.

(2) Medical provider appeals and administrative reviews involving the Division are governed by OAR 410-120-1560 through 410-120-1600.

(3) Complaints and appeals for clients requesting or receiving medical assistance from a Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) shall be governed exclusively by the procedures in OARs 410-141-3260 to 410-141-3262 and 410-141-0260 to 410-141-0262. This rule describes the procedures applicable when those clients request and are eligible for a Division contested case hearing.

(4) Contested Case Hearing Requests:

(a) A client has the right to a contested case hearing in the following situations upon the timely completion of a request for a hearing:

(A) The Authority acts to deny client services, payment of a claim, or to terminate, discontinue or reduce a course of treatment, or issues related to disenrollment in a CCO or PHP; or

(B) The right of a client to request a contested case hearing is otherwise provided by statute or rule, including OAR 410-141-0264 when a client of a PHP or 410-141-0364 when a client of a CCO may request a state hearing.

(b) To be timely, a request for a hearing is complete when the Division receives the Division approved appeal and hearing forms not later than the 45th day following the date of the decision notice;

(c) In the event a request for hearing is not timely, the Division will determine whether the client showed there was good cause, as defined in OAR 137-003-0501(7) for their failure to timely file the hearing request. In determining whether to accept a late hearing request, the Division requires the request to be supported by a written statement that explains why the request for hearing is late. The Division may conduct such further inquiry as the Division deems appropriate. If the Division finds

that the client has good cause for late filing, the Division will refer the case to the OAH for a contested case hearing. The following factual disputes will be referred to the OAH for a hearing:

(A) Whether the hearing request was received timely;

(B) Whether the client received the notice of action;

(C) The information included in the client's statement of good cause.

(d) In the event the claimant has no right to a contested case hearing on an issue, the Division may enter an order accordingly. The Division may refer a hearing request to the Office of Administrative Hearings for a hearing on the question of whether the claimant has a right to a contested case hearing;

(e) A client who requests a hearing shall be referred to as a claimant. The parties to a contested case hearing are the claimant and, if the claimant has requested a hearing about a decision of a CCO or PHP, the claimant's CCO or PHP;

(f) A client may be represented by any of the persons identified in ORS 183.458. A CCO or PHP that is a corporation may be represented by any of the persons identified in ORS 410.190.

(5) Expedited hearings:

(a) A claimant who feels his or her medical or dental problem cannot wait for the normal review process may be entitled to an expedited hearing;

(b) Expedited hearings are requested using Authority Form 443 or other Division approved appeal and/or hearing request forms;

(c) Division staff will request all relevant medical documentation and present the documentation obtained in response to that request to the Division Medical Director or the Medical Director's designee for review. The Division Medical Director or the Medical Director's designee will decide if the claimant is entitled to an expedited hearing within, as nearly as possible, two working days from the date of receiving the documentation applicable to the request;

(d) An expedited hearing will be allowed, if the Division Medical Director or the Medical Director's designee, determines that the claimant has a medical condition which is an immediate, serious threat to claimant's life or health and claimant has been denied a medical service.

(6) Informal conference:

(a) The Division hearing representative and the claimant, and their legal representative if any, may have an informal conference, without the presence of the Administrative law Judge (ALJ), to discuss any of the matters listed in OAR 137-003-0575. The informal conference may also be used to:

(A) Provide an opportunity for the Division and the claimant to settle the matter;

(B) Provide an opportunity to make sure the claimant understands the reason for the action that is subject of the hearing request;

(C) Give the claimant and the Division an opportunity to review the information that is the basis for that action;

(D) Inform the claimant of the rules that serve as the basis for the contested action;

(E) Give the claimant and the Division the chance to correct any misunderstanding of the facts;

(F) Determine if the claimant wishes to have any witness subpoenas issued for the hearing; and

(G) Give the Division an opportunity to review its action.

(b) The claimant may, at any time prior to the hearing date, request an additional informal conference with the Authority representative, which may be granted if the Authority representative finds, in his or her sole discretion, that the additional informal discussion will facilitate the hearing process or resolution of disputed issues;

(c) The Division may provide to the claimant the relief sought at any time before the Final Order is served;

(d) Any agreement reached in an informal conference shall be submitted to the ALJ in writing or presented orally on the record at the hearing.

(7) A claimant may withdraw a hearing request at any time. The withdrawal is effective on the date it is received by the Division or the ALJ, whichever is first. The ALJ will send a Final Order confirming the withdrawal to the claimant's last known address. The claimant may cancel the withdrawal up to the tenth calendar day following the date such an order is effective.

(8) Contested case hearings are closed to non-participants in the hearing; however, a client may choose to have another person present.

(9) Proposed and Final Orders:

(a) In a contested case, an ALJ assigned by the Office of Administrative Hearings will serve a proposed order on all parties and the Division, unless, prior to the hearing, the Division notifies the ALJ that a final order may be served. The proposed order issued by the ALJ will become a final order if no exceptions are filed within the time specified in subsection (b) unless the Division notifies the parties and the ALJ that the Division will issue the final order;

(b) If the ALJ issues a proposed order, a party adversely affected by the proposed order may file exceptions to the proposed order or present argument for the Division's consideration:

(A) The exceptions must be in writing and reach the Division not later than 10 working days after date the proposed order is issued by the ALJ;

(B) After receiving the exceptions, if any, the Division may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, the Authority will issue an amended proposed order.

(10) A hearing request is dismissed by order when neither the party nor the party's legal representative, if any, appears at the time and place specified for the hearing. The order is effective on the date scheduled for the hearing. The Division will cancel the dismissal order on request of the party upon the party being able to show good cause, as defined in OAR 137-003-0501(7), as to why they were unable to attend the hearing and unable to request a postponement.

(11) The final order is effective immediately upon being signed or as otherwise provided in the order. A final order resulting from the claimant's withdrawal of the hearing request is effective the date the claimant withdraws. When claimant fails to appear for the hearing and the hearing request is dismissed by final order, the effective date of the order is the date of the scheduled hearing.

(12) All contested case hearing decisions are subject to judicial review under ORS 183.482 in the Court of Appeals.

[ED. NOTE: Forms referenced are available from the agency.] Stat. Auth.: ORS 183.341 & 413.042

Stats. Implemented: ORS 183.411 - 183.470, 414.025, 414.055 & 414.065

410-120-1865 – Denial, Reduction, or Termination of Services

(1) The purpose of this rule is to describe the requirements governing the denial, reduction or termination of medical assistance, and access to the Division of Medical Assistance Programs (Division) administrative hearings process, for clients requesting or receiving medical assistance services paid for by the Authority on a fee-for-service basis. Complaint and appeal procedures for clients receiving services from a Prepaid Health Plan shall be governed exclusively by the procedures in OAR 410-0141-0260.

(2) When the Authority authorizes a course of treatment or covered service, but subsequently acts (as defined in 42 CFR 431.201) to terminate, suspend or reduce the course of treatment or a covered service, the Authority or its designee shall mail a written notice to the client at least ten (10) calendar days before the date of the termination or reduction of the covered service unless there is documentation that the client had previously agreed to the change as part of the course of treatment or as otherwise provided in 42 CFR 431.213.

(3) The written client notice must inform the client of the action the Authority has taken or intends to take and reasons for the action; a reference to the particular sections of the statutes and rules involved for each reason identified in the notice; the client's right to request an administrative hearing; an explanation of the circumstances under which benefits may continue pending resolution of the hearing; and how to contact the Authority for additional information. The Authority is not required to grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.

(4) The Authority shall have the following responsibilities in relation to continuation or reinstatement of benefit under this rule:

(a) If the client requests an administrative hearing before the effective date of the client notice and requests that the services be continued, the Authority shall continue the services. The service shall be continued until whichever of the following occurs first (but in no event should exceed ninety (90) days from the date of the client's request for an administrative hearing):

(A) The current authorization expires; or

(B) A decision is rendered about the case that is the subject of the administrative hearing; or

(C) The client is no longer eligible for medical assistance benefits, or the health service, supply or item that is the subject of the administrative hearing is no longer a covered benefit in the client's medical assistance benefit package; or

(D) The sole issue is one of federal or state law or policy and the Authority promptly informs the client in writing that services are to be terminated or reduced pending the hearing decision.

(b) The Division shall notify the client in writing that it is continuing the service. The notice shall inform the client that if the hearing is resolved against the client, the cost of any services continued after the effective date of the client notice may be recovered from the client pursuant to 42 CFR 431.230(b);

(c) The Authority shall reinstate services if:

(A) The Authority takes an action without providing the required notice and the client requests a hearing;

(B) The Authority does not provide the notice in the time required under section (2) of this rule and the client requests a hearing within 10 days of the mailing of the notice of action; or

(C) The post office returns mail directed to the client, but the client's whereabouts become known during the time the client is still eligible for services;

(D) The reinstated services must be continued until a hearing decision unless, at the hearing, it is determined that the sole issue is one of federal or state law or policy.

(d) The Authority shall promptly correct the action taken up to the limit of the original authorization, retroactive to the date the action was taken, if the hearing decision is favorable to the client, or the Authority decides in the client's favor before the hearing.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025, 414.055 & 414.065

410-120-1870 – Client Premium Payments

(1) All non-exempt clients in the benefit group are responsible for payment of premiums as outlined in OAR 461-135-1120.

(2) Nonpayment of premium can result in a disqualification of benefits per OAR 461-135-1130.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025, 414.055 & 414.065

410-120-1875 – Agency Hearing Representatives

(1) Subject to the approval of the Attorney General, an agency officer or employee is authorized to appear (but not make legal argument) on behalf of the Authority or Department in the following classes of hearings:

(a) Contested case hearings requested by clients in accordance with OAR 410-120-1860 and 410-130-1865; and

(b) Contested case hearings involving providers in accordance with OAR 410-120-1560 to 410-120-1700.

(2) Subject to the approval of the Attorney General, the Department of Human Services (Department) Audit Manager responsible for the Division of Medical Assistance Programs (Division) audits is authorized to appear (but not make legal argument) on behalf of the Authority in the following classes of hearings:

(a) Division overpayment determinations made in an audit under OAR 943120-1505 (provider audit);

(b) The Division provider sanction decisions made in conjunction with or in lieu of an overpayment determination in OAR 943-120-1505 (provider audit).

(3) Legal argument as used in ORS 183.452 and this rule has the same meaning as defined in OAR 137-003-0008(1)(c) and (d) 137-003-0545.

(4) When a Authority or Department officer or employee, or the Department Audit Manager, represents the Authority, the presiding officer will advise such representative of the manner in which objections may be made and matters preserved for appeal. Such advice is of a procedural nature and does not change applicable law on waiver or the duty to make timely objection. Where such objections involve legal argument, the presiding officer will provide reasonable opportunity for the Authority, Department officer or employee, or the Department Audit Manager, to consult legal counsel and permit such legal counsel to file written legal argument within a reasonable time after the conclusion of the hearing.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025 & 414.065

410-120-1880 – Contracted Services

(1) Except as otherwise provided in OAR 410-120-1260 et seq. applicable to provider enrollment or OAR 410-141-0000, 410-141-3010 et seq. governing CCO or PHPs, insurance and service contracts as provided for under ORS 414.115, 414.125, 414.135 and 414.145 may be implemented for covered medical assistance services in any program area(s) of the Oregon Health Authority (Authority) in order to achieve one or more of the following purposes:

(a) To implement and maintain CCO or PHP services;

(b) To ensure access to appropriate Medical Services that would not otherwise be available;

(c) To more fully specify the scope, quantity, or quality of the services to be provided or to specify requirements of the provider or to specify requirements of the Authority in relation to the provider;

(d) To obtain services more cost effectively, (e.g., to reduce the costs of program administration or to obtain comparable services at less cost than the fee-for-service rate).

(2) Contracts, interagency agreements, or intergovernmental agreements under OAR 410-120-1880, subsection (1) funded with federal funds will be subject to applicable federal procurement and contracting requirements, and this rule will be interpreted and applied to satisfy such requirements. To the extent required by the federal funding agency, the Authority will seek prior federal approval of solicitations and/or contracts when the Authority plans to acquire or enhance services or equipment that will be paid in whole or on part with federal funds.

(3) The Authority is exempt from the Public Contracting Code for purposes of source selection pursuant to ORS 279A.025(2). The Authority will use the following source selection procedures when entering into contracts under OAR 410-120-1880, subsection (1). Interagency agreements and intergovernmental agreements are not subject to competitive solicitation as the basis of source selection, and may be selected in accordance with ORS 190.003 to 190.130 and other applicable law or authority. Competition must be used in obtaining contract services to the maximum extent practical, except as otherwise provided in subsection (4):

(a) Small procurement procedure may be used for the procurement of supplies and services less than or equal to $5,000. The Authority may use any method reasonably appropriate to the nature of the supply or service and the business needs of the Authority to identify potential contractors;

(b) Informal solicitation procedure may be used for the procurement of services if the estimated cost or contract price is $150,000 or less. Proposals will be solicited from at least three sources, except as otherwise provided in these rules;

(c) Formal solicitation procedure will be used for the procurement of services when the estimated cost or contract price is more than $150,000. Proposals must be solicited as outlined in these rules.

(4) Selection by negotiation may be used in lieu of a competitive procurement under subsection (3) of this rule for the procurement of goods or services if:

(a) The good or service is available only from a single source or the sole source has special skills that are only available based upon his or her expertise or situation. If the Authority Director, or designee, determines that only a single contractor is available or practical for purposes of this rule, the Director or designee may approve selection by negotiation. A memorandum signed by the Director or designee setting forth the reasons for using a sole source contract must be placed in the contract file;

(b) Public need, significant risk of interruption of services, or emergency advises against a delay incident to competitive solicitation. If the Authority Director, or designee, determines that an emergency exists for purposes of this rule, the Director or designee may approve selection by negotiation. A memorandum signed by the Director or designee setting forth the nature of the emergency must be placed in the file;

(c) Compliance with federal requirements necessitated proceeding without competitive solicitation. Documentation of the applicable federal requirements must be placed in the contract file;

(d) Other authority including but not limited to statutory authority in ORS 414.115, 414.125, 414.135, and 414.145, or such other authority, exemptions and delegations of authority that may be applicable to the source selection for the procurement: Documentation of the authority must be placed in the contract file.

(5) A Request for Proposal (RFP) or similar solicitation mechanism must be prepared for contracts for which the Formal Solicitation Procedure will be used. The solicitation document should include at a minimum the following elements, when applicable:

(a) Statement of required work, including a clear description of the services to be provided, standards by which performance of the services will be measured and/or conditions affecting the delivery of services;

(b) Minimum standards and qualifications which contractors must meet to be eligible to provide the services;

(c) Information which the prospective contractors must submit in their proposals to support their capability, such as references and experience providing the same or similar services (when, where, for whom, type of service, etc.);

(d) Funding information and budget requirements;

(e) Information about ownership interests in software or hardware designed, acquired, developed or installed with federal funds, in compliance with federal requirements for ownership, management and disposition;

(f) The form and organization of proposals, when and where proposals are to be submitted, whether late proposals may be considered, and when an award of a contract is expected;

(g) The method and criteria to be used in evaluating proposals and the weighting assigned to each criterion;

(h) Provisions stating how and when the solicitation document must be contested, and how and when the final award must be contested;

(i) Notice that all costs incurred in the preparation of a proposal will be the responsibility of the proposer and will not be reimbursed by the Authority; and

(j) Contract provisions, subject to subsection (8) of this rule.

(6) Proposals must be evaluated in a manner consistent with the evaluation criteria in the solicitation document. A written document stating why the selection was made will be placed in the contract file.

(7) Unless exempt under ORS 291.045 to 291.049 or rules adopted there under, the Authority will obtain the review and approval of the solicitation document, contract or agreement by the Department of Justice.

(8) The terms and conditions of the contract to be awarded to a contractor selected using these source selection rules will be governed by the Public Contracting Code, except for interagency agreements or intergovernmental agreements exempt under ORS 279A.025(2), or contracts or agreements under other exemptions from the Public Contracting Code. The Public Contracting Code, if applicable, and such delegation of authority, if any, as may be made by the Department of Administrative Services to the Authority determine contract approval authority.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.115, 414.125, 414.135, 414.145 & 414.740

410-120-1920 – Institutional Reimbursement Changes

(1) The Division of Medical Assistance Programs (Division) is required under federal regulations, 42 CFR 447, to submit specific assurances and related information to the Centers for Medicare and Medicaid Services (CMS) whenever it makes a significant change in its methods and standards for setting payment rates for inpatient hospital services or long-term care facilities.

(2) A "significant change" is defined as a change in payment rates that affects the general method of payment to all providers of a particular type or is projected to affect total reimbursement for that particular type of provider by six percent or more during the 12 months following the effective date.

(3) Federal regulation specifies that a public notice must be published in one of the following:

(a) A state register similar to the Federal Register. For the Oregon Health Authority (Authority), the state register is the Oregon Bulletin published by the Secretary of State;

(b) The newspaper of widest circulation in each city with a population of 50,000 or more;

(c) The newspaper of widest circulation in the state, if there is no city with a population of 50,000 or more;

(d) The Authority web site for public notices.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065 & 414.755

1-1-12

410-120-1940 – Interest Payments on Overdue Claims

(1) Upon request by the provider, the Division of Medical Assistance Programs (Division) will pay interest on an overdue claim:

(a) A claim is considered "overdue" if the Division does not make payment within 45 days of receipt of a valid claim;

(b) The interest rate shall be the usual rate charged by the provider to the provider's clientele, but not more than 2/3 percent per month or eight percent per year.

(2) When billing the Division for interest on an overdue valid claim the provider must furnish the following information in writing:

(a) Name of the service and the location the service was provided;

(b) The name of the client who received the service;

(c) client ID Number;

(d) Date of service;

(e) Date of initial valid billing of the Division;

(f) Amount of billing on initial valid claim;

(g) The Division’s Internal Control Number (ICN) of claim;

(h) Certification, signed by the provider or the provider's authorized agent, that the amount claimed does not exceed the usual overdue account charges assessed by the provider to the provider's clientele.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025 & 414.065

410-120-1960 – Payment of Private Insurance Premiums

(1) The Private Insurance Premium (PHI) and Health Insurance Premium Payment (HIPP) Program is a cost saving program administered by the Oregon Health Authority (Authority) and the Department of Human Services (Department) for Medicaid enrollees. When a Medicaid client or eligible applicant has employer sponsored group health insurance or private health insurance the Authority or Department may choose to reimburse a portion or the entire insurance premium, if it is determined to be cost effective for the Authority or Department.

(2) The Authority or Department may pay health insurance policy premiums or otherwise enter into agreements with other health insurance plans that comply with ORS 414.115 to 414.145 on behalf of eligible individuals when:

(a) The client is enrolled in full coverage Medicaid as indicated by the program acronym CEM, EXT, GAM, MAA, MAF, OHP (except OHP-CHP and OHP-OPU), OSIPM, and SAC;

(b) The policy is a comprehensive major medical insurance plan (comparable to the Medicaid State Plan coverage) and at a minimum provides the following;

(i) Physician services;

(ii) Hospitalization (inpatient and outpatient);

(iii) Outpatient Lab, x-ray, immunizations; and

(iv) Full prescription Drug coverage.

(c) The payment of premiums and/or co-insurance and deductibles is likely to be cost-effective, as determined under section (5) of this rule;

(d) An eligible applicant may be a non-Medicaid individual living in or outside the household. The Authority or Department may pay the entire premium (excluding the employer's portion) if payment of the premium including that individual is cost-effective, and if it is necessary to include that individual in order to enroll the Authority or Department client in the health plan. The Authority or Department shall not reimburse for policies that are for the purpose of providing court ordered health insurance.

(3) The Authority or Department shall not pay private health insurance premiums for:

(a) Non-SSI institutionalized and waivered clients whose income deduction is used for payment of health insurance premiums;

(b) A policy that has limited benefits where the Authority or Department's annual cost for the premiums exceeds the benefit limits of the policy..

(c) Medicaid eligible clients enrolled in Medicare part A and/or Part B.

(d) Non-major medical stand alone policies such as dental, vision, cancer, accident only.

(4) The Authority or Department shall assure that all Medicaid covered services continue to be made available to Medicaid-eligible individuals for whom the Authority or Department elects to purchase all or a portion of their private or employer sponsored health insurance.

(5) Assessment of cost-effectiveness shall include:

(a) The Medical Savings Chart (MSC) is used to obtain the Cost Effectiveness rate for each Medicaid eligible.

(b) In cases where there is more than one Medicaid eligible covered by a single insurance policy, the cost effectiveness rates are combined and compared to the cost of the insurance premium. If the combined cost effectiveness rate total is greater than the cost of the premium it is approved as cost effective.

(c) If the monthly premium exceeds the allowable amount on the MSC, the Authority or Department may elect to review the current and probable future health status of the Medicaid client based upon their existing medical conditions, previous medical history, age, number of dependents, and other relevant health status indicators. The Authority or Department may apply a special conditions rate in addition to the cost effectiveness rate on the MSC to determine if their premium is cost effective.

(6) The Authority or Department may purchase documents or records necessary to establish or maintain the client's eligibility for other insurance coverage.

(7) The Authority or Department shall not make payments for any benefits covered under the private health insurance plan, except as follows:

(a) The Authority or Department shall calculate the Authority or Department's allowable payment for a service. The amount paid by the other insurer shall be deducted from the Authority or Department allowable. If the Authority or Department allowable exceeds the third party payment, the Authority or Department shall pay the provider of service the difference;

(b) The payment made by the Authority or Department shall not exceed any co-insurance, copayment or deductible due;

(c) The Authority or Department shall make payment of co-insurance, copayments or deductibles due only for covered services provided to Medicaid-eligible clients.

(8) Any change of insurance coverage must be reported to the Authority or Department within 10 days of the change to minimize any overpayment made on the client's behalf. Changes that must be reported include but are not limited to:

(a) Private or employer-sponsored insurance is no longer active (ends);

(b) Family member added or dropped from health insurance plan;

(c) Change in health insurance plan or health plan coverage;

(d) Change in employer resulting in change in health insurance plan;

(e) Change in health plan premium cost;

(f) Change in employment status (lay off/termination, short-term disability)

(g) Address changes

(9) As a condition of eligibility, clients are required to pursue assets (OAR 461-120-0330), and required to obtain medical coverage (OAR 461-1200345). Failure to notify the Authority or Department worker of insurance coverage or changes in such coverage, and failure to provide periodic required documentation for PHI/HIPP may impact continued eligibility.

(10) The effective date for starting reimbursement of cost-effective PHI/HIPP premiums is the first of the next new month following the eligibility determination, providing the insurance is still active.

(11) Cancellation of premium payment shall result when:

(a) Client(s) is no longer eligible for Medicaid;

(b) No longer covered by the employer sponsored or private health insurance plan;

(c) Health insurance premium is no longer cost effective for the Authority or Department:

(d) Failure to submit or complete Redetermination forms and/or provide documentation required by the Authority or Department to complete Redetermination;

(e) Client or eligible applicant fails to use the Authority or Department's premium payment reimbursement to pay for their private insurance, if they are required to pay the insurance directly;

(f) If the policy-type changes (Primary policy changes to a supplemental policy) or the clients eligibility changes to a category that does not meet the requirements in (2).

(12) The Authority or Department determines where approved premium payments should be sent; to the policy holder (or authorized representative); the employer; or the insurance carrier.

(13) The client or eligible applicant's receipt of payment under this rule is intended for the express purpose of insurance premium payment, or reimbursement of client paid insurance premium.

(14) Redetermination of premium payments will occur:

(a) Annually for continued cost effectiveness and may also be reviewed more frequently to ensure insurance is active;

(b) When changes with Medicaid, insurance eligibility or employment have been reported or identified;

(c) Other reasons determined by the Department.

(15) Clients do not have hearing rights as outlined in OAR 410-120-1855 for a denial of private insurance premium payment. The Authority or Department's decision to place a client in the PHI/HIPP program is not an eligibility determination, nor a denial of a Medicaid benefit.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025, 414.065 & 414.115, 414.125, 414.135 & 414.145

1-1-12

410-120-1980 – Requests for Information and Public Records

(1) The Division of Medical Assistance Programs (Division) will make nonexempt public records available for inspection to persons making a public records request under ORS 192.410 to 192.500.

(2) The Division may charge a fee for copies of non-exempt public records to cover actual costs per OAR 407-003-0010.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 192.410 - 192.500