

Secretary of State  
**NOTICE OF PROPOSED RULEMAKING HEARING**  
A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority (OHA), Division of Medical Assistance Programs (Division)	410	
Agency and Division	Administrative Rules Chapter Number	
Sandy Cafourek	500 Summer St NE, Salem, OR 97301	(503) 945-6430
Rules Coordinator	Address	Telephone

**RULE CAPTION**

Add Acronym for CCO Where PHP Referenced, Housekeeping, Codification, and Clarification of Overpayments Language

June 16, 2015	10:30 a.m.	500 Summer St. NE, Salem, OR 97301 Room 160	Sandy Cafourek
Hearing Date	Time	Location	Hearings Officer

*Auxiliary aids for persons with disabilities are available upon advance request.*

**RULEMAKING ACTION**

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

**ADOPT:**

**AMEND:** OAR 410-120-0025, 410-120-1280, 410-120-1360, 410-120-1510, 410-120-1560 and 410-120-1960

**REPEAL:**

**RENUMBER:**

**AMEND & RENUMBER:**

Stat. Auth. : ORS 413.042

Other Auth.:

Stats. Implemented: ORS 414.025, 414.065, 414.115, 414.125, 414.135 & 414.145

**RULE SUMMARY**

The Division is amending these rules to reference CCO appropriately where PHP is referenced and make several technical housekeeping revisions, codification corrections, and clarifications for electronic signatures and overpayments.

The agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

June 18, 2015 by 5 p.m. Send written comments to: [dmap.rules@state.or.us](mailto:dmap.rules@state.or.us)  
**Last Day for Public Comment** (Last day to submit written comments to the Rules Coordinator)

	DAVID SINNITT	4/11/2015
Signature	Printed name	Date

**Note:** Hearing Notices must be submitted by the 15th day of the month to be published in the next month's *Oregon Bulletin*.

**STATEMENT OF NEED AND FISCAL IMPACT**

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division)	410
Agency and Division	Administrative Rules Chapter Number

Add Acronym for CCO Where PHP Referenced, Housekeeping, Codification, and Clarification of Overpayments Language	
Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)	

In the Matter of: The amendment of OAR 410-120-0025, 410-120-1280, 410-120-1360, 410-120-1510, 410-120-1560, and 410-120-1960.

Statutory Authority: ORS 413.042

Other Authority:

Stats. Implemented: 414.025, 414.065, 414.115, 414.125, 414.135 & 414.145

Need for the Rule(s): The General Rules program administrative rules govern Division payments for services to clients.

The Division needs to amend the following rules:

410-120-0025 to replace the acronym PHP to CCO wherever PHP's are currently referenced in order to be consistent with chapter 410 division 141 rules.

410-120-1280- is being amended to provide clarification that the reference to a limited benefit package is the CAWEM benefit in this rule.

410-120-1360 - Technical revision to clarifying the policy for use of electronic signatures.

410-120-1510 - Technical revision that changes "or" to "and."

410-120-1560 - Codification correction.

410-120-1960 - is being amended to clarify language consistent with the Affordable Care Act, and add clear language as it relates to over payments.

Documents Relied Upon, and where they are available:

410-120-1360- Medicare Program Integrity Manual

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>

ORS Chapter 84 <http://www.oregonlaws.org/ors/chapter/84>

Fiscal and Economic Impact: None

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

Amending these rules will have no fiscal impact on the Authority other state agencies, local government, clients, the public, or businesses, including small businesses.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

c. Equipment, supplies, labor and increased administration required for compliance:

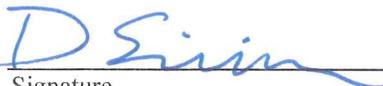
How were small businesses involved in the development of this rule?

Small businesses were invited to participate in a Rule Advisory Committee, none participated however, they are not impacted by these rule amendments.

Administrative Rule Advisory Committee consulted?: Yes

If not, why?:

Approximately two weeks prior to the rules advisory committee meeting a public notice was posted on the agency website, an invitation was emailed to more than 250 people that had expressed interest in the rule making process. Those invited range from large hospital affiliates, national and local Durable Medical Equipment businesses, local independent Pharmacies, Pharmacy chains, individually owned physician and Dental offices, medical and hospital associations, advocacy groups etc.



Signature

DAVID SIMMITT

Printed Name

4/1/2015

Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

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), ORS 414.651 (Coordinated Care Organizations), and ORS 414.115 to 414.145 (services contracts), subject to the rulemaking requirements of the 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, Coordinated Care Organizations, and the Prepaid Health Plans ~~shall~~ 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 Coordinated Care Organizations, the requirements applicable to the providing covered medical assistance to Division clients are found in OAR 410-141-3000 through 410-141-3485; and where applicable, OAR 410-120-0000 through 410-120-1980; and the provider rules applicable to the category of medical service;

(D) ~~Generally for Prepaid Health Plans, the requirements applicable to the providing provision of~~ covered medical assistance to Division clients are ~~found 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,~~ OAR 410-120-0000 through 410-120-1980; and the provider rules applicable to the category of medical service;

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

~~(EE)~~ 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

~~(GF)~~ The basic framework for provider enrollment in OAR 943-120-0300 through 943-120-0380 that 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 ~~paragraphs~~ ~~subsections~~ (A) – ~~(EE)~~ of this section.

(b) For purposes of contract administration solely as between the Authority and its Coordinated Care Organizations or Prepaid Health Plans, the terms of the applicable contract and the requirements in subsection (2)(a) of this rule ~~apply~~ apply 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 individual ~~person~~ or entity unless the individual ~~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

## **410-120-1280**

### **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) ~~may~~ 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 ~~may not~~ 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 ~~may not~~ 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 ~~may~~ must not bill the Division more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Division pProgram 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, divisions 120 and 141, ~~OAR chapter 410, division 141,~~ or any other individual Division pProgram rules;

(b) The client did not inform the provider of their OHP coverage, enrollment in a PHP or CCO ~~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 ~~the~~ limited-benefit package: Citizen Alien Waived Emergency MedicalProgram (CWM) benefit package. CAWEM clients have the benefit package identifier of CWM. Clients receiving CAWEM benefits may be billed for services that are not part of the CAWEM benefits, of those programs, refer to (See 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 covered ~~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 ~~shall pay~~ 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, indicating that the provider gave the client the information described in section (3)(g)(A-C); and that 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 provider must give a copy of the signed agreement to the client. ~~must be given a copy of the signed agreement.~~ A provider may~~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 thesueh 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 set forth~~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 shall~~will~~ adhere to the Code Set requirements in 45 CFR 162.1000 — 162.1011;

(c) Periodically, the Division shall~~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 shall~~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 as coverage, or as 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 ~~p~~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, ~~or in addition to~~ the National Provider Identification (NPI) number, if the NPI is available, pursuant to OAR 410-120-1260;

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

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

(e) Claims m~~M~~ust be for services provided within the provider's licensure or certification;

(f) Unless otherwise specified, claims m~~M~~ust 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~~ must 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), may~~ 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, items~~(s)~~, or services~~(s)~~ that has~~ve~~ 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 ~~thesuch~~ 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 ~~p~~Program rules;

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

(c) Hospitals ~~must~~~~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 ~~p~~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 services~~(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 ~~p~~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 ~~may~~~~must~~ not ~~"unbundle"~~ 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 ~~shall~~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 section (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 the 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 ~~may~~ 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 section (8)(d)(A through E) above, the provider may choose to bill the primary insurance prior to billing the Division. Otherwise, the Division shall will process the claim and, if applicable, ~~will~~ pay the Division's 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 ~~shall~~ 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 pProgram 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 that which identifies the original claim, name and number of the client, date of service and items~~(s)~~ or services~~(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 ~~may~~ 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. Pursuing 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 ~~provided~~ 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 ~~may~~ 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 the 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 ~~shall~~ 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);  
or 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.

[ED. NOTE: Tables referenced are not included in rule text. [Click here for PDF copy of table\(s\).](#)]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

#### **410-120-1360**

#### **Requirements for Financial, Clinical, and Other Records**

(1) The Authority shall be responsible for analyzing, and monitoring, audit, and verify the accuracy and appropriateness of payment, utilization of services, medical necessity, medical appropriateness, quality of care, and access to care of the Medical Assistance Programs and the Children's Health Insurance Program.

~~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.~~ (2) 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 that which supports the specific care, items, or services for which payment has been requested. Payment shall will be made only for services that are adequately documented. Documentation shall must be completed before the service is billed to the Division and meet the following requirements:~~

(a) All records shall 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 is was provided, and the individual who provided the service. Patient account and

financial records ~~shall~~ 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 pProvider ~~shall~~ is required to maintain adequate records to thoroughly explain how the amounts reported on the cost statement were determined. The records ~~shall~~ must be accurate and in sufficient detail to substantiate the data reported;

(b) Clinical records, including records of all therapeutic services, ~~shall~~ must document the cClient's diagnosis and the medical need for the service. The cClient's record ~~shall~~ must be annotated each time a service is provided and signed or initialed by the individual who provided the service or ~~shall~~ must clearly indicate the individual(s) who provided the service. For purposes of medical review, the Authority adopts Medicare's electronic signature policy as outlined in the CMS Medicare Program Integrity Manual. Information contained in the record ~~shall~~ must be appropriate in quality and quantity to meet the professional standards applicable to the pProvider or practitioner and any additional standards for documentation found in this rule, the individual pProvider rules, and any ~~relevant~~ pertinent contracts;

(c) Electronic Data Transmissions shall comply with the Uniform Electronic Transactions Act cited in ORS chapter 84 and OAR 943-120-0100;

~~(d) Have P~~ policies and procedures ~~shall~~ to ensure the maintenance of the confidentiality of medical record information. These procedures ensure the pProvider may release such information in accordance with federal and state statutes, ORS 179.505 through 179.507, ORS 411.320, and ORS 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.~~

~~(e2)~~ Retain clinical records for seven years and financial and other records described in ~~paragraphs~~ 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, Medicaid Fraud Unit, or DHHS, may review and copy the original documentation in the pProvider's place of business. Upon the written request of the pProvider, the pProgram or the uUnit may, at their sole discretion, modify or extend the time for providing ~~such~~ records if, in the opinion of the pProgram or uUnit good cause for ~~an~~ 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 pProvider 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 cClient 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, and medical appropriateness of care, items, and services provided; or

(d) To facilitate payment authorization and related services; or

(e) To investigate a cClient's contested case 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 may, ~~and accordingly~~ subjects the pProvider to possible denial or recovery of payments made by the Division or to sanctions.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.115, 414.125, 414.135, 414.145

**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. For the purpose of these ~~As used in these rules, the terms have the following definitions apply~~ meanings:

(a) "Credible allegation of fraud" means an allegation of fraud, ~~that~~ 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) ~~shall~~ will not reimburse a specific provider who has defrauded or abused ~~the Authority or Department~~ for items or services ~~which that~~ 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 ~~shall~~ 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 ~~which~~ 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 ~~provided~~ 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 ~~provided~~ rendered, and the identity of the individual who ~~provided~~ rendered the services; or of the recipient of the services;

(e) Duplicate billing of the Medicaid ~~p~~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.

(3) ~~The p~~Provider ~~shall~~ 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's)~~ Provider Audit Unit (PAU). ~~For~~ Contact information ~~may be found online at:~~ see the General Rules Supplemental Information Guide online at [www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html](http://www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html) <http://www.oregon.gov/oha/healthplan/Pages/general-rules.aspx>.

~~(43)~~ If the ~~p~~Provider ~~is~~ aware of suspected fraud or abuse by an Authority or Department client (i.e., ~~provider reporting Authority or Department client fraud and abuse~~), the provider shall ~~must~~ report the incident to the Department's Fraud Investigations Unit (FIU). For ~~e~~Contact information may be found online at <http://www.oregon.gov/oha/healthplan/Pages/general-rules.aspx>; see the General Rules Supplemental Information Guide online at [www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html](http://www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html).

~~(54)~~ The ~~p~~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.

~~(65)~~ Providers and their fiscal agents shall ~~must~~ disclose ownership and control information; and disclose information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, CHIP, or the Title XX services program. Such disclosure and reporting is made a part of the provider enrollment agreement, and the provider shall ~~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 shall ~~must~~ be construed in a manner that is consistent with the Authority or Department acting in compliance with those federal requirements.

~~(76)~~ The Authority or Department may share information for health oversight purposes with the MFCU and other federal or state health oversight authorities.

~~(87)~~ 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.

~~(98)~~ The Authority or Department ~~may~~ ~~is~~ ~~authorized~~ to take the actions necessary to investigate and respond to credible allegations of ~~f~~Fraud and ~~a~~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 ~~s~~Sanctions provided under state law or regulations. ~~These~~ Such actions by the Authority or Department may be reported to the Centers for Medicare and Medicaid Services CMS, or other federal or state entities as appropriate.

~~(109)~~ The Authority or Department shall ~~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.

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 an individual ~~person~~ or entity enrolled with the Division, or under contract with the Division that is subject to the Division rules and; 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 an individual ~~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 set forth 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 an individual ~~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 Authority’s Addictions and Mental Health Division ~~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 set forth in OAR 410-141-0000;

(g) Coordinated Care Organization (CCO) has the meaning set forth 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 including but not limited to ~~such as~~ the following:

(a) A denial or limitation of payment allowed for services or items provided;

(b) A denial related to an 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 ~~Division~~ 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 ~~must~~ 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:

(A) ~~Within~~ 180 calendar days ~~from~~ the date of the Division's fee-for-service decision;

(B) ~~Within~~ 30 calendar days ~~from~~ the date of the CCO or PHP decision ~~after~~ the provider completes the appeal to the CCO or PHP appeal process.

(5) Types and methods for provider appeals are: ~~listed below.~~

(a) Claim redeterminations: 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) Contested Case: 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 may be entitled to appeal a notice of sanction as a contested case may choose to 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) Administrative review: All provider appeals of Division decisions not described in ~~section paragraphs~~ (4)(a) or (b) are handled as administrative reviews in accordance with OAR 410-120-1580, unless the 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 ~~the~~such a decision to the Division as an administrative review, and the Division may accept ~~the~~such review;

(d) This rule does not apply to contract administration issues that may arise solely between the Division and a CCO or PHP. ~~Those~~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 or PHP. In general, the relationship between a CCO or PHP and their providers is a contract matter between them. Client appeals are ~~governed by~~handled under the client appeal rules, not provider appeal rules.

(A) 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

(B) 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 CCO or PHP 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

(C) 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 ~~OHPregon 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~~s~~;

(Div) A timely provider request for 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 shall~~will~~ be treated as a participant in the appeal.

(7) ~~Ifn the event~~ a provider's request for ~~provider~~ appeal is not timely, the Division shall~~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~~s~~;

(a) Consistent with OAR 410-120-1360, payment on a claim shall~~will~~ ~~only~~ be made only 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~~s~~;

(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, shall~~will~~ be held in Salem, unless otherwise stipulated to by all parties and agreed to by the Division.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042

**410-120-1960**

**Payment of Private Insurance Premiums**

~~(1) The Private Insurance Premium (PHI) and Health Insurance Premium Payment (HIPP) Program are~~ is a cost saving programs administered by the Oregon Health Authority (Authority) and the Department of Human Services (Department) for Medicaid enrollees. When a Medicaid client or eligible enrollee applicant ~~is~~ has ~~is covered by~~ employer sponsored group health insurance or private health insurance, the Authority or Department may choose to reimburse all or a portion ~~of the entire of the~~ 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 a full coverage Medicaid program approved by the Authority or Department as indicated by the program acronym CEM, EXT, GAM, MAA, MAF, OHP (except ~~OHP-CHP and OHP-OPU~~), OSIPM, and SAC (excluding CHIP and CAWEM);

(b) The policy is a comprehensive major medical insurance plan (comparable to the Medicaid State Plan coverage) and at a minimum provides the following:;

~~(A)~~ (i) Physician services;

~~(B)~~ (ii) Hospitalization (inpatient and outpatient);

~~(C)~~ (iii) Outpatient ~~lab~~, x-ray, immunizations; and

~~(D)~~ (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 the non-Medicaid ~~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 waived 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, and Part C;:-

(d) Non-major medical stand-alone policies such as dental, vision, cancer, or accident only;

(e) When the purpose of the policy is providing court ordered health insurance.

(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 client;

(b) In cases where there is more than one Medicaid eligible client 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 ~~may~~ 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~~ may 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 ~~shall~~ must be reported to the Authority or Department within ~~ten~~ 10 days of the change. If the Authority or Department determines reimbursement of premiums were made on behalf of the client for a policy no longer in effect, the payee shall be liable for repayment to the Authority or Department for the full amount of any overpayment

established. T-to minimize any overpayment made on the client's behalf. ~~c-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 or /termination, short-term disability);

(g) Address changes.

(9) As a condition of eligibility, clients must ~~are required to~~ pursue assets (OAR 461-120-0330); and ~~required to~~ obtain medical coverage (OAR 461-120-0345). 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) If it is determined that reimbursement of premiums is cost-effective, payments shall begin in the next new month following the determination; however, the Authority or Department may approve a retroactive payment when appropriate. 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) A cClient(s) is no longer eligible for a medical program approved by the Authority or Department ~~Medicaid;~~

(b) A client is n ~~No longer covered by the employer-~~sponsored or private health insurance plan;

(c) A h ~~Health insurance premium is no longer cost effective for the Authority or Department;~~

(d) Failure to submit or complete r ~~Redetermination forms and/or provide documentation required by the Authority or Department to complete r~~Redetermination;

(e) A c ~~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) The ~~If the policy-type changes (p~~Primary policy changes to a supplemental policy) or the client's eligibility changes to a category that does not meet the requirements in section (2).

(12) The Authority or Department ~~shall~~ determines where approved premium payments ~~shall~~~~should~~ be sent to: ~~to~~ the policy holder (or authorized representative), ~~the employer,~~ or the insurance carrier, ~~or some other entity.~~

(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. If insurance is canceled because payment was used for purposes other than premium payment, an overpayment may occur.

(14) Redetermination for HIPP/PHI reimbursement shall~~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 medical program~~Medicaid~~, insurance eligibility, or employment have been reported or identified;

(c) Other reasons determined by the Authority or Department.

(15) Payment of premiums is a reimbursement and not a medical benefit; therefore, c~~lients 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 a reimbursement and not an eligibility determination, nor a denial of a medical program~~~~Medicaid~~ benefit.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.115, 414.125, 414.135 & 414.145

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

Use in Field "9" on the CMS-1500

<b>Single Insurance Coverage</b>	
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)
<b>Multiple Insurance Coverage</b>	
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)

OHP Client Agreement to Pay for Health Services



This is an agreement between a 'client' and a 'provider,' as defined in OAR 410-120-0000. The client agrees to pay the provider for health service(s) not covered by the Oregon Health Plan (OHP), coordinated care organizations (CCOs) or managed care plans. For the purposes of this Agreement "services" include but are not limited to health treatment, equipment, supplies and medications.

Provider Section

1 Health care services requested:

Procedure codes (CPT/HCPCS):

2 Expected date(s) of service:

3 Condition being treated:

4 Estimated fees \$ to \$

- Check one: [ ] There are no other costs that are part of this service. [ ] There may be other costs that are part of this service and you may have to pay for them, too. Other procedures that usually are part of this service may include: [ ] Lab [ ] X-ray [ ] Hospital [ ] Anesthesia [ ] Other

- 5 As your provider:
• Where applicable, I have tried all reasonable covered treatments for your condition.
• I have verified that the proposed services are not covered.
• Where appropriate, I have informed you of covered treatments for your condition, and you have selected a treatment that is not covered.

Provider Name: NPI:

Provider Signature: Date:

OHP Client Section

6 Client Name: DOB: Client ID#:

- 7 I understand:
• That the health care services listed above are not covered for payment by OHP, my CCO or managed care plan.
• If I get the services above I agree to pay the costs. After having the services, I will get bills for them that I must pay.
• I have read the back of this form and understand my other options.

I have been fully informed by the provider of all available medically appropriate treatment, including services that may be paid for by the Division of Medical Assistance Programs (DMAP) or DMAP-contracted CCOs or managed care plans, and I still choose to get the specified service(s) listed above.

Client (or representative's) signature: Date:

If signed by the client's representative, print their name here:

8 Witness signature: Date:

Witness name:

This agreement is valid only if the estimated fees listed above do not change and the service is scheduled within 30 days of the member's signature.

Client - Keep a copy of this form for your records

## **Attention OHP Client – Read this information carefully before you sign.**

Before you sign you should be sure the service is not covered by OHP or your Coordinated Care Organization (CCO) or managed care plan. Here are some things you can do:

① **Check to make sure the service is not covered**

DMAP, your CCO or plan will send you a Notice of Action if they do not cover a service that your provider requests. If you did not receive a Notice of Action, ask your CCO, plan or provider to send you one so you can be sure the service is not covered by OHP.

② **Request an Appeal and or Hearing**

Once you have a Notice of Action, you can request an Appeal or Hearing. Read the Notice of Action carefully. It will explain why the service was denied. It will also give you information about your right to appeal the denial or ask for a hearing.

If you also have Medicare, you may have other Appeal rights. If you have both OHP and Medicare, call 800-Medicare (800-633-4227) or TTY 711.

③ **Check to see if there are other ways to get the service**

Ask your provider if:

- They have tried all other covered options available for treating your condition.
- There is a hospital, medical school, service organization, free clinic or county health department that might provide this service, or help you pay for it.

Will your OHP benefits, or any other health insurance you may have, change soon? If so, try to find out if this service will be covered when your benefits change.

④ **Ask about reduced rates and discounts**

Ask your provider if they can offer you a reduced rate for the service or if they offer discounts for people who pay for services privately. They may have nothing to offer you, but you won't know unless you ask.

⑤ **Get a second opinion**

You may find another provider who will charge you less for the service.

### **Additional costs**

There may be services from other providers – like hospital, anesthesia, therapy or laboratory services – that go with the service you want. You will have to pay for these, too. Ask your provider for the names and phone numbers of the other providers. Contact those providers to find out what their charges will be.

### **Questions?**

- Call your plan or CCO's Customer Service department, or
- Call the OHP Client Services Unit at 800-273-0557, TTY 711
- Call the Public Benefits Hotline at 800-520-5292 if you would like legal advice about OHP benefits and paying for services.

## **Attention Provider – Relevant Oregon Administrative Rules (OARs)**

Requirements of this Agreement are outlined in OAR 410-120-1280, Billing, and 410-141-3395, Member Protection Provisions. These rules can be found online at:

[http://arcweb.sos.state.or.us/pages/rules/oars\\_400/oar\\_410/410\\_tofc.html](http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_tofc.html)