Secretary of State

# NOTICE OF PROPOSED RULEMAKING

A Statement of Need and Fiscal Impact accompanies this form.

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

| | | |
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| Sandy Cafourek | 500 Summer St. NE, Salem, OR 97301 | 503-945-6430 |
| Rules Coordinator | Address | Telephone |

**RULE CAPTION**

Annual Relative Value Unit (RVU) Weight Update Effective January 1, 2014

**Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.**

**RULEMAKING ACTION**

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

**ADOPT:**

**AMEND:** OAR 410-120-1340

**REPEAL:**

**RENUMBER:**

**AMEND and RENUMBER:**

Stat. Auth.: ORS **413.042**

Other Auth.:

Stats. Implemented: ORS **414.025, 414.033, 414.065, 414.095, 414.705, 414.727, 414.728, 414.742, 414.743**

**RULE SUMMARY**

**DMAP will permanently amend this rule to implement the annual update to the Centers for Medicare and Medicaid (CMS) Relative Value Unit (RVU) weights for physician services.**

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.

March 20, 2014 by 5:00 p.m. dmap.rules@state.or.us

**Last Day for Public Comment** (Last day to submit written comments to the Rules Coordinator)

| | | |
|---|---|---|
| Judy Mohr Peterson | Judy Mohr Peterson | 02/13/2014 |
| Signature | Printed name | Date |

**Note:** Notices must be submitted by the 15th day of the month to be published in the next month's *Oregon Bulletin.* A Rulemaking Hearing may be requested in writing by 10 or more people, or by an association with 10 or more members, within 21 days following notice publication or 28 days from the date notice was sent to people on the agency's interested party mailing list, whichever is later. In such cases a Hearing Notice must be published in the *Oregon Bulletin* at least 14 days before the hearing.

Secretary of State

# 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

Annual Relative Value Unit (RVU) Weight Update Effective January 1, 2014

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 410-120-1340**

Statutory Authority: **ORS 413.042**
Other Authority:
Stats. Implemented: **ORS 414.025, 414.033, 414.065, 414.095, 414.705, 414.727, 414.728, 414.742, 414.743**

Need for the Rule(s): **Having temporarily amended 410-120-1340 effective January 1, 2014, DMAP will permanently amend this rule to implement the annual update to the Centers for Medicare and Medicaid (CMS) Relative Value Unit (RVU) weights for physician services.**

Documents Relied Upon, and where they are available:
**Federal register, Vol. 78, No.237 published December 10, 2013**
**http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28696.pdf**

Fiscal and Economic Impact: **Amending these rules will have a savings to the Authority but no impact to other state agencies, local government, clients. Small businesses impact will vary depending upon the rate of utilization and how the RVU weight changes for that particular procedure code; some will go up, and some will go down.**

Statement of Cost of Compliance:

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

**The Division has approximately 63,000 enrolled providers. These enrolled providers range from large hospital affiliates, national Durable Medical Equipment or Pharmacy chains to individually owned physician offices. The Division's fee-for-services providers serve approximately 10 percent of the total OHP population. The Division does not have available information to estimate the percentage of these medical practices that are small businesses. The impact to these smaller provider groups will vary depending upon the rate of utilization and how the RVU weight changes for that particular specialty. The RVU update is a standard reimbursement methodology for all payers, and CMS calculates the costs associated with the visit and adjusts the RVU weight to account for variations in office costs and other factors. The payment method for the drugs administered by physicians is being corrected in these rules to be consistent with the pharmacy program rules.**

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: **None**

c. Equipment, supplies, labor and increased administration required for compliance: **None**

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

**Because these proposed rules implement the annual RVU update by the Centers for Medicare and Medicaid, small business providers did not participate in the development of these rules.**

Administrative Rule Advisory Committee consulted?: **No,**

If not, why?: **Because the proposed rules implement the annual update to the RVUs by Centers for Medicare and Medicaid, a formal rule advisory committee was not consulted.**

Judy Mohr Peterson — Signature

JUDY MOHR PETERSON — Printed name

02/13/2014 — Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310. ARC 925-2007

**410-120-1340**

**Payment**

(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 2014~~2013~~ Total RVU weights published in the Federal Register, Vol. ~~77~~78, December 10, 2013~~November 16, 2012 with technical corrections published Dec. 14, 2012,~~ to be effective for dates of services on or after January 1, 2014~~2013~~:

(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;

(iii) $27.82 for other Oregon primary care providers and services not specified in (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, 2014~~3~~, The Division will calculate rates for each RVU weight-based code using statewide Geographic Practice Cost Indices (GPCIs) as follows:

(i) Work RVU) X (Work GPCI of ~~1.0~~.986) + (Practice Expense RVU) X (Practice GPCI of ~~0.969~~0.972) + (Malpractice RVU) X (Malpractice GPCI of ~~0.625~~0.667);

(ii) Sum in (D)(i) multiplied by the applicable conversion factor in section 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% of the 2014~~2013~~ Medicare clinical lab fee schedule;

(C) All approved Ambulatory Surgical Center (ASC) procedures are reimbursed at 80% of the ~~2012~~2013 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%. 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 (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 Division's Hospital Services Program administrative rules (chapter 410, division 125). Reimbursement for services, including claims paid at DRG rates, shall 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) Aged and Physically Disabled Division (APD) will 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, 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 shall 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 shall 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 which 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); and

(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 will 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 cannot exceed the co-insurance and deductible amounts due;

(b) The Division pays the Division allowable rate for Division covered services that are not covered by Medicare.

(16) For clients with third-party resources (TPR), the Division pays the Division 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, such 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, 414.705, 414.727, 414.728, 414.742 & 414.743