

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

Oregon Health Authority (OHA), Health Systems Division, 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**

Enroll and Reimburse Specialty Hospitals Classified as Long-Term Acute Care Hospitals  
**Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.**

June 15, 2016	10:30 a.m.	500 Summer St. NE, Salem, OR 97301 Room 137B	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:** 410-120-0000; 410-125-0080; 410-125-0141; 410-125-0400

**REPEAL:**

**RENUMBER:**

**AMEND & RENUMBER:**

Stat. Auth. : ORS 413.042;414.065

Other Auth.:

Stats. Implemented: ORS 414.065

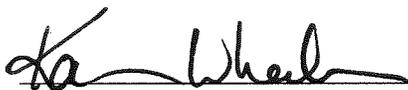
**RULE SUMMARY**

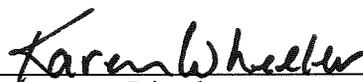
The Oregon Health Authority (Authority) is proposing to reimburse specialty hospitals classified as Long-Term Acute Care Hospitals (LTACH) that are eligible for reimbursement for services that meet the definition at 42CFR 440.10. LTACH furnish extended medical and rehabilitative care to individuals with clinically complex problems such as multiple acute or chronic conditions that need hospital-level care for relatively extended periods. To qualify as a LTACH for payment, a facility must meet Medicare's conditions of participation for acute care hospitals.

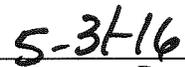
The agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

June 17, 2016 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)

  
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), Health Systems Division, Medical Assistance Programs (Division)	410
Agency and Division	Administrative Rules Chapter Number

Enroll and Reimburse Specialty Hospitals Classified as Long-Term Acute Care Hospitals
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 410-120-0000; 410-125-0080, 410-125-0141, and 410-125-0400

Statutory Authority: ORS 413.042 & 414.065  
Other Authority:  
Stats. Implemented: ORS 414.065

Need for the Rule(s): The Authority needs to amend OARs to allow reimbursement to a new type of specialty hospital, Long-Term Acute Care Hospital (LTACH). LTACHs provide services to patients with complex medical needs requiring long-term hospitalization in an acute setting. Many patients are admitted directly from short stay hospital's intensive care units with respiratory/ventilator dependent or other complex medical conditions.

- OAR 410-120-0000 – Acronym and Definitions: Revising the definition of Hospital to include Long-Term Acute Care Hospitals and add definition of a Long-Term Acute Care Hospital.
- OAR 410-125-0080 – Inpatient Services: Add prior authorization requirements for Long-Term Acute Care services.
- OAR 410-125-0141 – DRG Rate Methodology: Reimbursement methodology for Long-Term Acute Care Hospitals to include LTC-DRG reimbursement, high cost outliers, and short stay outliers. Long-Term Acute Care Hospitals not eligible for Graduate Medical Education and Disproportionate Share payments.
- OAR 410-125-0400 – Discharge: Clarify transfer policy to a Long-Term Acute Care Hospital.

Documents Relied Upon, and where they are available:  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf>.

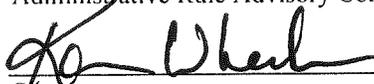
Fiscal and Economic Impact: No significant fiscal impact is anticipated with this rule change. Patients transferring from a general acute care hospital setting into a LTAC should reduce the inpatient cost. Patients eligible for a LTAC require a longer length of stay that turns into an outlier payment if left in a general acute care setting. Estimated Savings: 2016 FF \$28,821, 2017 FF \$115,287.

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, units of local government, 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: Amending these rules will not impact small businesses.
  - b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: Amending these rules will not add additional reporting, record keeping, or other administrative activities.
  - c. Equipment, supplies, labor and increased administration required for compliance: Amending these rules will not impose any new equipment, supplies, labor and increased administration requirements on small or large businesses

How were small businesses involved in the development of this rule? Approximately two weeks prior to the rules advisory committee meeting, a public notice was posted on the agency website. An invitation was e-mailed to more than 250 people that had expressed interest in the rulemaking process in meetings referenced above. Those invited are made up of large and small providers, groups, and associations.

Administrative Rule Advisory Committee consulted?: Yes, a RAC was held on April 6, 2016. If not, why?:

	Karen Wheeler	5/3/16
Signature	Printed Name	Date

410-125-0080

## Inpatient Services

(1) Elective (not urgent or emergent) hospital admission:

(a) Coordinated Care Organization (CCO), ~~Fully-Capitated Health Plan (FCHP)~~, and Mental Health Organization (MHO) clients: Contact the client's CCO, ~~FCHP~~, or MHO. The health plan may have different prior authorization (PA) requirements than the Division of Medical Assistance Programs (Division);

(b) Medicare clients: The Division does not require PA for inpatient services provided to clients with Medicare Part A or B coverage;

(c) Division clients: Oregon Health Plan (OHP) clients covered by the OHP Plus Benefit Package:

(A) For a list of medical and surgical procedures that require PA, see the Division's Medical-Surgical Services Program, rules OAR chapter 410, division 130, specifically OAR 410-130-0200, table 130-0200-1, unless they are urgent or emergent defined in OAR 410-125-0401;

(B) For PA, contact the Division unless otherwise indicated in the Medical-Surgical Service Program rules, specifically OAR 410-130-0200, Table 130-0200-1.

(2) Transplant services:

(a) Complete rules for transplant services are in the Division's Transplant Services Program rules, OAR chapter 410, division 124;

(b) Clients are eligible for transplants covered by the Oregon Health Evidence Review Commission's Prioritized List of Health Services (Prioritized List). See the Transplant Services Program administrative rules for criteria. ~~For clients enrolled in a FCHP, contact the plan for authorization. Clients not enrolled in a FCHP, contact the Division's Medical Director's office.~~

(3) Out-of-State non-contiguous hospitals:

(a) All non-emergent and non-urgent services provided by hospitals more than 75 miles from the Oregon border require PA;

(b) Contact the Division's Medical Director's office for authorization for clients not enrolled in a Prepaid Health Plan (PHP). For clients enrolled in a PHP, contact the plan.

(4) Out-of-State contiguous hospitals: The Division prior authorizes services provided by contiguous-area hospitals, less than 75 miles from the Oregon border, following the same rules and procedures governing in-state providers.

(5) Transfers to another hospital:

(a) Transfers for the purpose of providing a service listed in the Medical-Surgical Services Program rules, specifically OAR 410-130-0200, Table 130-0200-1, e.g., inpatient physical rehabilitation care, require PA. Contact the Division-contracted Quality Improvement Organization (QIO);

(b) For transfers to a ~~long-term, acute-care hospital~~, skilled nursing facility, intermediate care facility, or swing bed, contact Aging and People with Disabilities (APD). APD reimburses nursing facilities and swing beds through contracts with the facilities. For CCO and FCHP clients, transfers require authorization and payment (for first 20 days) from the CCO or FCHP;

(c) For transfers for the same or lesser level inpatient care to a general acute-care hospital, the Division shall cover transfers, including back transfers that are primarily for the purpose of locating the patient closer to home and family, when the transfer is expected to result in significant social or psychological benefit to the patient:

(A) The assessment of significant benefit shall be based on the amount of continued care the patient is expected to need (at least seven days) and the extent to which the transfer locates the patient closer to familial support;

(B) Payment for transfers not meeting these guidelines may be denied on the basis of post-payment review.

(d) Exceptions:

(A) Emergency transfers do not require PA;

(B) In-state or contiguous non-emergency transfers for the purpose of providing care that is unavailable in the transferring hospital do not require PA unless the planned service is listed in the Medical-Surgical Service Program rules, specifically OAR 410-130-0200, Table 130-0200-1;

(C) All non-urgent transfers to out-of-state, non-contiguous hospitals require PA.

(6) Dental procedures provided in a hospital setting:

(a) For prior authorization requirements, see the Division's Dental Services Program rules; specifically OAR 410-123-1260 and 410-123-1490;

(b) Emergency dental services do not require PA;

(c) For prior authorization for fee-for-service clients, contact the Division's Dental Services Program analyst. (See the Division's Dental Services Program Supplemental information, <http://www.oregon.gov/OHA/healthplan/pages/dental.aspx>);

(d) For clients enrolled in a CCO or FCHP, contact the client's health plan.

(7) Long-term acute care (LTAC) hospital services authorization requirements:

(a) For an initial thirty-day stay:

(A) LTAC provider must, before admitting the client, submit a request for prior authorization to the Division;

(B) Include sufficient medical information to justify the requested initial stay;

(C) Meet the clinical criteria outlined in the LTAC Hospital guide at:  
<http://www.oregon.gov/oha/healthplan/Pages/hospital.aspx>.

(b) Extension of stay:

(A) Submit request for prior authorization to the Division;

(B) Include sufficient medical justification for the extended stay.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

**410-125-0141**

### **DRG Rate Methodology**

(1) Diagnosis Related Groups:

(a) Diagnosis Related Groups (DRG) is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM);

(b) The DRG classification methodology assigns a DRG category to each inpatient service, based on the patient's diagnoses, age, procedures performed, length of stay, and discharge status.

(2) Medicare Grouper: The Medicare Grouper is the software used to assign an individual claim to a DRG category. Medicare revises the Grouper program each year in October. The Division of ~~Medical Assistance Programs (Division)~~ uses the Medicare Grouper program in the assignment of inpatient hospital claims. The most recent version of the Medicare grouper will be installed each year within 90 days of the date it is implemented by Medicare. Where better assignment of claims is achieved through changes to the grouper logic, the Division may modify the logic of the grouper program. The Division will work with representatives of hospitals that may be affected by grouper logic changes in reaching a cooperative decision regarding changes. The Division DRG weight tables can be found on the Division web site:

(a) Acute Care Hospitals larger than fifty beds are considered DRG hospitals and reimbursed using Medicare's MS-DRG grouper;

(b) Hospitals enrolled as long-term acute care (LTAC) are reimbursed using Medicare's MS-LTC DRG grouper.

(3) DRG Relative Weights:

(a) Relative weights are a measure of the relative resources required in the treatment of the average case falling within a specific DRG category;

(b) For most DRGs, the Division establishes a relative weight based on federal Medicare DRG weights. For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs, Oregon Title XIX fee-for-service claims history is used. To determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRG, the Division uses the following methodology: Using the formula  $N = \frac{Z \cdot S}{R}$  where  $Z = 1.15$  (a 75 percent confidence level),  $S$  is the standard deviation, and  $R = 10$  percent of the mean. The Division determines the minimum number of claims required to set a stable weight for each DRG ( $N$  must be at least 5). For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs lacking sufficient volume, the Division sets a relative weight using:

(A) Division non-Title XIX claims data; or

(B) Data from other sources expected to reflect a population similar to the Division Title XIX caseload;

(c) When a test shows at the 90 percent confidence level that an externally derived weight is not representative of the average cost of services provided to the Division Title XIX population in that DRG, the weight derived from the Division Title XIX claims history is used instead of the externally derived weight for that DRG;

(d) Those relative weights based on Federal Medicare DRG weights, will be established when changes are made to the DRG Grouper logic. State-specific relative weights shall be adjusted, as needed, as determined by the Division. When relative weights are recalculated, the overall Case Mix Index (CMI) will be kept constant. Reweighting of DRGs or the addition or modification of the grouper logic will not result in a reduction of overall payments or total relative weights.

(4) Case Mix Index: The hospital-specific case mix index is the total of all relative weights for all services provided by a hospital during a period, divided by the number of discharges.

(5) Unit Value: Hospitals larger than fifty ~~(50)~~ beds or enrolled as a long-term acute care (LTAC) hospital ~~beds~~ are reimbursed using the Diagnosis Related Grouper (DRG) as described in section (2). Effective for services on or after:

(a) August 15, 2005, the operating unit payment is 100 percent of 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge;

(b) May 1, 2009, the operating unit payment is 108.5 percent% of the 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge;

(c) Effective October 1, 2009 the operating unit payment is 100 percent% of the most recent version of the Medicare base payment rates. The Division will revise the base payment rates each year in October when Medicare posts the rates.

(6) DRG Payment: The DRG payment to each Oregon DRG hospital or LTAC hospital is calculated by adding the unit value to the capital amount, then multiplied by the claim assigned DRG relative weight (out-of-state hospitals do not receive the capital amount).

(7) DRG Hospital Cost Outlier Payments:

(a) Cost outlier payments are an additional payment made to in-state and contiguous hospitals for exceptionally costly services or exceptionally long lengths of stay provided to Title XIX and SF (State Facility) clients;

(b) For dates of service on and after March 1, 2004, the calculation to determine the cost outlier payment for Oregon DRG hospitals is as follows:

(A) Non-covered services (such as ambulance charges) are deducted from billed charges;

(B) The remaining billed charges are converted to hospital-specific costs using the hospital's cost-to-charge ratio derived from the most recent audited Medicare cost report and adjusted to the Medicaid caseload;

(C) If the hospital's net costs as determined above are greater than 270 percent of the DRG payment for the admission and are greater than \$25,000, an additional cost outlier payment is made;

(D) Costs which exceed the threshold (\$25,000 or 270 percent% of the DRG payment, whichever is greater) are reimbursed using the following formula:

(i) Billed charges less non-covered charges, multiplied by;

(ii) Hospital-specific cost-to-charge ratio equals;

(iii) Net Costs, minus;

(iv) 270 percent% of the DRG or \$25,000 (whichever is greater), equals;

(v) Outlier Costs, multiplied by;

(vi) Cost Outlier Percentage, (cost outlier percentage is 50 percent%), equals;

(vii) Cost Outlier Payment;

(E) Third party reimbursements are deducted from the Division calculation of the payable amount;

(F) When hospital cost reports are audited during the cost settlement process, an adjustment will be made to cost outlier payments to reflect the actual Medicaid hospital-specific cost-to-charge ratio during the time cost outlier claims were incurred. The cost-to-charge ratio in effect for that period of time will be determined from the audited Medicare Cost Report and cost statement template, adjusted to reflect the Medicaid mix of services, and DMAP-42, adjusted to reflect the Medicaid mix of services;

(8) LTAC Short Stay Outliers: Occurs when a covered length of stay is between one day and up to and including 5/6ths of the average length of stay for the LTC-DRG grouping. The Short Stay Outlier payment for the hospital will be the lesser of:

(a) Per Diem for Short Stay Outlier Calculation:

(A) MS-LTC DRG payment, divided by;

(B) Geometric Length of Stay (GLOS,) multiplied by;

(C) Actual length of stay, multiplied by;

(D) 120 percent equals;

(E) Per Diem payment;

(b) Full MS-LTC DRG payment.

(9) LTAC High Cost Outliers: Are an additional payment when the estimated cost of a claim exceeds the outlier threshold (LTC DRG payment plus a fixed loss amount):

(a) The fixed loss amount is published annually by Medicare;

(b) If the estimated cost of a claim is greater than the outlier threshold, an additional payment is added to the LTC DRG payment;

(c) The outlier payment is 80 percent of the difference between the estimated cost of the claim and the outlier threshold (LTC DRG payment plus the fixed loss amount);

(d) The estimated cost of the claim is calculated by multiplying the Division's allowable charge on the claim by the hospital's cost-to-charge ratio.

(10) Capital:

(a) The capital payment is a reimbursement to in-state hospitals for capital costs associated with the delivery of services to Title XIX, non-Medicare persons. The Division uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) For the dates of service on and after March 1, 2004, the Capital cost per discharge is ~~one hundred~~(100) percent of the published Medicare capital rate for fiscal year 2004, see section (5). The capital cost is added to the Unit Value and paid per discharge;

(c) Effective October 1, 2009, the Capital cost per discharge is one ~~hundred~~(100) percent of the current year Medicare capital rate and updated every October thereafter, see section (5). The capital cost is added to the Unit Value and paid per discharge.

(114) Direct Medical Education:

(a) The direct medical education payment is a reimbursement to in-state hospitals for direct medical education costs associated with the delivery of services to Title XIX eligible persons. The Division uses the Medicare definition and calculation of direct medical education costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) Direct medical education cost per discharge is calculated as follows:

(A) The direct medical education cost proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986, through June 30, 1987, are divided by the number of Title XIX non-Medicare discharges. This is the Title XIX direct medical education cost per discharge;

(B) The Title XIX direct medical education cost per discharge for this period is inflated forward to January 1, 1992, using the compounded HCFA-DRI market basket adjustment;

(c) Direct medical education payment per discharge:

(A) The number of Title XIX non-Medicare discharges from each hospital for the quarterly period is multiplied by the inflated Title XIX cost per discharge. This determines the current quarter's Direct Medical Education costs. This amount is then multiplied by 85 percent%. Payment is made within thirty days of the end of the quarter;

(B) The Direct Medical Education Payment per Discharge will be adjusted at an inflation factor determined by the Department in consideration of inflationary trends, hospital productivity, and other relevant factors.

(C) Notwithstanding subsection (9) of this rule, this subsection becomes effective for dates of service:

(i) On July 1, 2006, and thereafter direct medical education payments will not be made to hospitals; and

(ii) On July 1, 2008, and thereafter direct medical education payments will be made to hospitals, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained.

(1240) Indirect Medical Education:

(a) The indirect medical education payment is a reimbursement made to in-state hospitals for indirect medical education costs associated with the delivery of services to Title XIX non-Medicare clients;

(b) Indirect medical education costs are those indirect costs identified by Medicare as resulting from the effect of teaching activity on operating costs;

(c) Indirect medical education payments are made to in-state hospitals determined by Medicare to be eligible for such payments. The indirect medical education factor in use by Medicare for each of these eligible hospitals at the beginning of the sState's fiscal year is the Division indirect medical education factor. This factor is used for the entire Oregon fiseaFiscal yearYear;

(d) For dates of service on and after March 1, 2004, the calculation for the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital-specific February 29, 2004, Unit Value, multiplied by the Indirect Factor, equals the Indirect Medical Education Payment;

(e) Effective October 1, 2009, the calculation of the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital unit value, see (5)(c), multiplied by the indirect factor, equals the Indirect Medical Education Payment;:-

(f) This determines the current quarter's Indirect Medical Education Payment. Indirect medical education payments are made quarterly to each eligible hospital. Payment for indirect medical education costs will be made within thirty days of the end of the quarter;:-

(g) Notwithstanding subsection (10) of this rule, this subsection becomes effective for dates of service:

(A) On July 1, 2006, and thereafter Indirect Medical Education payment will not be made to hospitals; and

(B) On July 1, 2008, and thereafter Indirect Medical Education payments will be made to hospitals, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained.

~~{Publications: Publications referenced are available from the agency.}~~

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

## 410-125-0400

### Discharge

(1) A discharge from a hospital is the formal release of a patient to home, to another facility, such as an intermediate care facility or nursing home, to a home health care agency, or to another provider of health care services.

(2) For services beginning January 1, 1993, and later, the transfer of a patient from acute care to a distinct part physical rehabilitation unit (i.e., a unit exempt from the Medicare Prospective Payment System) within the same hospital will be considered a discharge. The admission to the rehabilitation unit is billed separately. All other transfers occurring within a hospital, including transfers to Medicare PPS-exempt psychiatric units, will not be considered discharges, and all charges for services must be submitted on a single UB-04 billing for the admission.

(3) Transfer from a hospital occurs when an individual is formally released to another acute care hospital, to a long-term acute care hospital, to a skilled nursing facility, or an intermediate care facility. When a physician sends a patient directly to another hospital for further inpatient care, the discharge should be billed as a transfer, regardless of the mode of transportation.

(4) When the Division receives claims from two hospitals for the same patient, and the date of discharge from one hospital is the same as the date of admission to the other, the Division will assume that a transfer has occurred. The Division will change the discharge status code on the first claim to 02 (Transferred to Another Acute Care Facility), automatically generating an adjustment if the claim has already been adjudicated, unless discharge status on the claim is already 02 (Transfer) or 07 (Discharge AMA). If it is believed that the Division made an error in assigning Discharge Status code 02 to a claim, the hospital may submit an Adjustment Request along with supporting documentation from the medical record.

(5) A transfer between units within a hospital is not a transfer for billing purposes, except in the case of transfers to distinct part physical rehabilitation units. Note that transfers in the other direction, from rehabilitative care to acute care, are not considered discharges from the rehabilitation unit unless the stay in the acute setting exceeds seven days. Stays of seven days or less in the acute care setting ~~should~~may not be billed separately.

(6) Some transfers, including transfers to distinct part rehabilitation units, require prior authorization.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

## 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), Health Systems 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) “Action” means a termination, suspension, or reduction of eligibility or covered services. For the definition as it is related to a CCO member, refer to OAR 410-141-0000.

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

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

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

(6) “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.

(7) “Addiction Division and Mental Health Division (AMH)” means ~~a the Divisions~~ within the Authority’s Health Systems Division that administers mental health and addiction programs and services.

(8) “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.

(9) “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.

(10) “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.

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

(12) “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).”

(13) “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.

(14) “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).

(15) “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.

(16) “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.

(17) “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).

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

(19) “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.

(20) “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).

(21) “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.

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

(23) “Appeal” means a request for review of an action.

(24) “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.

(25) “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.

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

(27) “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.

(28) “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.

(29) “Behavioral Health” means mental health, mental illness, addiction disorders, and substance use disorders.

(30) “Behavioral Health Assessment” means a qualified mental health professional’s determination of a member’s need for mental health services.

(31) “Behavioral Health Case Management” means services provide to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.

(32) “Behavioral Health Evaluation” means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.

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

(34) “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.

(35) “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.

(36) “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.)

(37) “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.

(38) “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.

(39) “Certified Traditional Health Worker” means an individual who has successfully completed a training program or doula training as required by OAR 410-180-0305, known to the Centers of Medicare and Medicaid as non-traditional health worker.

(40) “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.

(41) “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.

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

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

(44) “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).

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

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

(47) “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.

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

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

(50) “Co-morbid Condition” means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.

(51) “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.

(52) “Community Health Worker” means an individual who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;

(f) Provides health education and information that is culturally appropriate to the individuals being served;

(g) Assists community residents in receiving the care they need;

(h) May give peer counseling and guidance on health behaviors; and

(i) May provide direct services such as first aid or blood pressure screening.

(53) “Community Mental Health Program (CMHP)” means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority’s Addictions and Mental Health Division (AMH).

(54) “Condition/Treatment Pair” means diagnoses described in the International Classification of Diseases Clinical Modifications, 9th edition (ICD-109-CM); the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV); and treatments described in the Current Procedural Terminology, 4th edition (CPT-4); or American Dental Association Codes (CDT-2) or the Authority AMH Medicaid Procedure Codes and Reimbursement Rates, that, when paired by the Health Evidence Review Commission, constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.

(55) “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.

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

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

(58) “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.

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

(60) “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.)

(61) “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.

(62) “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.

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

(64) “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.

(65) “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.

(66) “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.

(67) “Declaration for Mental Health Treatment” means a written statement of an individual’s decisions concerning his or her mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment that is honored when the individual is unable to make such decisions.

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

(69) “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.

(70) “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.

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

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

(73) “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.

(74) “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.

(75) “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.

(76) “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.

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

(78) “Diagnosis Code” means as identified in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-109-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.

(79) “Diagnosis Related Group (DRG)” means a system of classification of diagnoses and procedures based on the ICD-910-CM.

(80) “Diagnostic Services” mean those services required to diagnose a condition, including but not limited to: radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.

(81) “~~Division of Medical Assistance Programs (Division)~~” means a the Health Systems division 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.

(82) “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.

(83) “Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medichex)” 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.

(84) “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.

(85) “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.

(86) “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.

(87) “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.

(88) “Emergency 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)).

(89) “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.

(90) “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.

(91) “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)).

(92) “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.

(93) “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.

(94) “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.

(95) “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.

(96) “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.

(97) “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.

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

(99) “Health Care Interpreter” Certified or Qualified as defined in ORS 413.550.

(100) “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.

(101) “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.

(102) “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.

(103) “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.

(104) “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.

(105) “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.

(106) “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.

(107) “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.

(108) “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.

(109) “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.

(110) “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.

(111) “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.

(112) “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.

(113) “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 as~~ 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.

(114) “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.

(115) “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).

(116) “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.

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

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

(119) “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.

(120) “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).

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

(122) “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.)

(123) “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.

(124) “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.

(125) “International Classification of Diseases, 9th Revision, Clinical Modification (ICD-109-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.

(126) “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).

(127) “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.

(128) “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.

(129) “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.

(130) “Long-Term Acute Care (LTAC) Hospital” means a facility that provides specialty care designed for patients with serious medical problems that require intense, special treatment for an extended period of time.

~~(130)~~(131) “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).

~~(131)~~(132) “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.

~~(132)~~(133) “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.

~~(133)~~(134) “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.

(13534) “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.

(1365) “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).

(1374) “Medical Services” means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.

(1378) “Medical Transportation” means transportation to or from covered medical services.

(1398) “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 CCO member in the Division or CCO’s judgment.

(1409) “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.

(1410) “Medicare Advantage” means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.

(14~~24~~) “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.

(14~~25~~) “Member” means an OHP client enrolled with a pre-paid health plan or coordinated care organization.

(14~~26~~) “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.

(14~~34~~) “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.

(14~~65~~) “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.

(14~~76~~) “Naturopathic physician” means a person licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.

(14~~87~~) “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.

(14~~99~~) “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.

(1504) “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.

(1514) “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).

(1524) “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.

(1532) “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.

(1543) “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.

(1554) “Nursing Facility” means a facility licensed and certified by the Department and defined in OAR 411-070-0005.

(1565) “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.

(1576) “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.

(1587) “Occupational Therapist” means a person licensed by the State Board of Examiners for Occupational Therapy.

(1598) “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.

(1605) “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.

(1610) “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.

(16~~5~~4) “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

(16~~12~~) “Optometric Services” means services provided within the scope of practice of optometrists as defined under state law.

(16~~13~~) “Optometrist” means a person licensed to practice optometry pursuant to state law.

(16~~54~~) “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.

(16~~65~~) “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.

(16~~76~~) “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.

(16~~87~~) “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.

(16~~98~~) “Overdue Claim” means a valid claim that is not paid within 45 days of the date it was received.

(17~~069~~) “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.

(17~~10~~) “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.

(17~~24~~) “Paid Provider” means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.

(1713) “Panel” means the Hearing Officer Panel established by section 3, chapter 849, Oregon Laws 1999.

(1713) “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.

(1714) “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.

(1765) “Peer Wellness Specialist” means an individual who is responsible for assessing mental health service and support needs of the individual’s peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.

(1776) “Person Centered Care” means care that reflects the individual patient’s strengths and preferences, reflects the clinical needs of the patient as identified through an individualized assessment, is based upon the patient’s goals, and will assist the patient in achieving the goals.

(1787) “Personal Health Navigator” means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient’s particular circumstances and in light of the patient’s needs, lifestyle, combination of conditions, and desired outcome.

(1798) “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.

(179180) “Pharmacist” means a person licensed to practice pharmacy pursuant to state law.

(1810) “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.

(1814) “Physical Therapist” means a person licensed by the relevant state licensing authority to practice physical therapy.

(1819) “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.

(1843) “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.

(1854) “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.

(1865) “Physician Services” means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.

(1876) “Podiatric Services” means services provided within the scope of practice of podiatrists as defined under state law.

(1887) “Podiatrist” means a person licensed to practice podiatric medicine pursuant to state law.

(1898) “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.

(1909) “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.

(1910) “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)

(1924) “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.

(1939) “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.

(1943) “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.

(1954) “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.

(1964) “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.

(1974) “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.

(1987) “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.)

(1998) “Public Health Clinic” means a clinic operated by a county government.

(2004) “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.

(2010) “Qualified Medicare Beneficiary (QMB)” means a Medicare beneficiary as defined by the Social Security Act and its amendments.

(2014) “Qualified Medicare and Medicaid Beneficiary (QMM)” means a Medicare beneficiary who is also eligible for Division coverage.

(2011) “Quality Improvement” means the efforts to improve the level of performance of a key process or processes in health services or health care.

(2013) “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.

(2014) “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.

(2015) “Recipient” means a person who is currently eligible for medical assistance (also known as a client).

(2016) “Recreational Therapy” means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).

(2017) “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.

(2018) “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.

(2019) “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.

(2110) “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.

(2124) “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.

(2130) “Representative” means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.

(2133) “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.

(2154) “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.

(2165) “Rural” means a geographic area that is ten or more map miles from a population center of 30,000 people or less.

(2174) “Sanction” means an action against providers taken by the Authority in cases of fraud, misuse, or abuse of Division requirements.

(2187) “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.

(2198) “Self-Sufficiency” means the division in the Department of Human Services (Department) that administers programs for adults and families.

(2204) “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.

(2210) “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.

(2224) “Social Worker” means a person licensed by the Board of Clinical Social Workers to practice clinical social work.

(2232) “Speech-Language Pathologist” means a person licensed by the Oregon Board of Examiners for Speech Pathology.

(2243) “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.

(2254) “State Facility” means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.

(2265) “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.

(2276) “Subrogation” means right of the state to stand in place of the client in the collection of third party resources (TPR).

(2287) “Substance Use Disorder (SUD) Services” means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the American Society of Addiction Medicine Patient Placement Criteria 2-Revision (ASAM PPC-2R). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).

(2293) “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.

(2304) “Surgical Assistant” means a person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(2310) “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.

(2311) “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.

(2331) “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.

(2343) “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.

(2354) “Transportation” means medical transportation.

(2369) “Service Authorization Request” means a member’s initial or continuing request for the provision of a service including member requests made by their provider or the member’s authorized representative.

(23~~7~~<sup>6</sup>) “Type A Hospital” means a hospital identified by the Office of Rural Health as a Type A hospital.

(23~~8~~<sup>8</sup>) “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.

(23~~9~~<sup>9</sup>) “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.

(24~~0~~<sup>9</sup>) “Type B Hospital” means a hospital identified by the Office of Rural Health as a Type B hospital.

(24~~1~~<sup>0</sup>) “Urban” means a geographic area that is less than ten map miles from a population center of 30,000 people or more.

(24~~2~~<sup>4</sup>) “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.

(24~~3~~<sup>2</sup>) “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.

(24~~4~~<sup>3</sup>) “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.

(24~~5~~<sup>4</sup>) “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).

(24~~56~~) “Valid Preauthorization” means a document the Authority, a PHP, or CCO receives requesting a health service for a member who would be eligible for the service at the time of the service, and the document contains:

(a) A beginning and ending date not exceeding twelve months, except for cases of PHP or CCO enrollment where four months may apply; and

(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.

(24~~76~~) “Vision Services” means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

(24~~87~~) “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.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065