

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

Oregon Health Authority, Division of Medical Assistance Programs	410	
Agency and Division	Administrative Rules Chapter Number	
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Rules Coordinator	Address	Telephone

**RULE CAPTION**

Revise form number and title of DMAP 1234 referenced in rules

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

**RULEMAKING ACTION**

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

**AMEND:** 410-141-0263, 410-141-3260

**REPEAL:**

**RENUMBER:**

**AMEND & RENUMBER:**

Stat. Auth.: ORS 413.042

Other Auth.:

Stats. Implemented: ORS 414.065

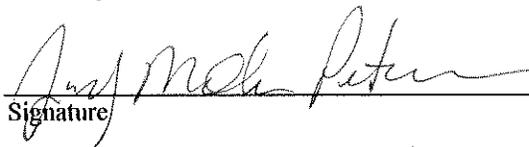
**RULE SUMMARY**

OAR 410-141-0263 and 410-141-3260 are being amended to change the name and form number of the DMAP 1234, referenced in the rules, to *Medical Assistance Programs Service Denial Appeal and Request* form, DMAP 3302.

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.

May 21, 2014

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

	Judy Mohr Peterson	05/14/2014
Signature	Printed name	Date

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

**STATEMENT OF NEED AND FISCAL IMPACT**

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

Oregon Health Authority, Division of Medical Assistance Programs

410

Agency and Division

Administrative Rules Chapter Number

Revise form number and title of DMAP 1234 referenced in rules

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 410-141-0263 and 410-141-3260

Statutory Authority: ORS 413.042

Other Authority:

Stats. Implemented: ORS 414,025, 414.065, 414.085

Need for the Rule(s): The Division needs to amend rules listed above to reflect a change in form number and title referenced in the rules. The form is used by clients requesting an appeal with their CCO/plan or a hearing with DMAP regarding denial of a requested health care service.

Documents Relied Upon, and where they are available: DMAP 3302, <http://www.oregon.gov/oha/healthplan/Pages/forms.aspx>

Fiscal and Economic Impact:

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): None

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: None

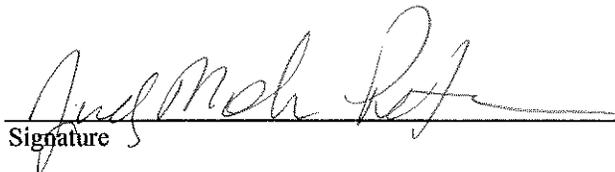
b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: None

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

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

Administrative Rule Advisory Committee consulted?: N/A

If not, why?: This is a housekeeping amendment following a change in a form number and title. No policies, procedures or requirements impacting clients, providers, coordinated care organizations or managed care plans have changed.

  
Signature

Judy Mohr PERENC 04/14/2014  
Printed name Date

**410-141-0263**

**Notice of Action by a Prepaid Health Plan**

The Division of Medical Assistance Programs (Division) may have specific definitions for common terms. Please use OAR 410-141-0000, Definitions, in conjunction with this rule.

(1) When a Prepaid Health Plan (PHP) (or authorized practitioner (see definition) acting on behalf of the PHP) takes or intends to take any "action," including but not limited to denials or limiting prior authorizations of a requested service(s) in an amount, duration, or scope that is less than requested, or reductions, suspension, discontinuation or termination of a previously authorized service, or any other action, the PHP (or authorized practitioner acting on behalf of the PHP) shall mail a written client (see definition) Notice of Action (NOA) in accordance with section (2) of this rule to the Division member (see definition) within the timeframes specified in subsection (3) of this rule.

(2) The written client Notice of Action must be on a Division approved form and must be used for all denials of a requested service(s), reductions, discontinuations or terminations of previously authorized services, denials of claims payment, or other action. The client Notice of Action must meet the language and format requirements of 42 CFR 438.10(c) and (d) and shall inform the Division member of the following:

(a) Relevant information shall include, but is not limited to, the following:

(A) Date of client Notice of Action;

(B) PHP name;

(C) PCP/PCD name;

(D) The Division member's name and ID number;

(E) Date of service or item requested or provided;

(F) Who requested or provided the item or service;

(G) Effective date of the action, if different from the date of the NOA;

(H) Whether the PHP considered other conditions as co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services;

(b) The action the PHP or its participating provider (see definition) has taken or intends to take;

(c) Reasons for the action, with enough specificity to clearly explain the actual reason for the denial, including but not limited to the following reasons:

(A) The item requires pre-authorization, and it was not pre-authorized;

(B) The service or item is received in an emergency care setting and does not qualify as an Emergency Service under the prudent layperson standard;

(C) The person was not a Division member at the time of the service or is not a Division member at the time of a requested service; and

(D) The provider is not on the PHP's panel and prior approval was not obtained (if such prior authorization would be required under the Oregon Health Plan rules);

(d) A reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Action pursuant to subsection (b) of this section, in compliance with the notice requirements in ORS 183.415(2)(c);

(e) The Division member's right to file an appeal with the PHP and how to exercise that right as required in OAR 410-141-0262;

(f) The Division member's right to request a Division administrative hearing and how to exercise that right. A copy of the following forms must be attached to the Notice of Action:

(A) Hearing Request form, (DHS 443), and the Notice of Hearing Rights, (DMAP 3030), or  
(B) The Medical Assistance Programs Service Denial Appeal and Hearing Request form, DMAP  
42343302, or approved facsimile.

(g) The circumstances under which expedited appeal resolution is available and how to request it;

(h) The Division member's right to have benefits continue pending resolution of the appeal, how to request that benefit(s) be continued, and the circumstances under which the Division member may be required to pay the costs of these services; and

(i) The telephone number to contact the PHP for additional information.

(3) The PHP or practitioner acting on behalf of the PHP must mail the Notice of Action within the following time frames:

(a) For termination, suspension, or reduction of previously authorized OHP covered services (see definition), the following time frames apply:

(A) The notice must be mailed at least ~~ten~~10 calendar days before the date of action, except as permitted under subsections (B) or (C) of this section;

(B) The PHP (or authorized practitioner acting on behalf of the PHP) may mail a notice not later than the date of action if:

(i) The PHP or practitioner receives a clear written statement signed by the Division member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying the information;

(ii) The Division member has been admitted to an institution where he or she is ineligible for covered services from the PHP;

(iii) The Division member's whereabouts are unknown and the post office returns PHP or practitioner's mail directed to him or her indicating no forwarding address;

(iv) The PHP establishes the fact that another sState, territory, or commonwealth has accepted the Division member for Medicaid services;

(v) A change in the level of medical or dental care is prescribed by the Division member's PCP or PCD; or

(vi) The date of action will occur in less than ~~ten~~10 calendar days, in accordance with 42 CFR 483.12(a)(5)(ii), related to discharges or transfers and long-term care facilities:

(C) The PHP may shorten the period of advance notice to five5 calendar days before the date of the action if the PHP has facts indicating that an action should be taken because of probable fraud by the Division member. Whenever possible, these facts should be verified through secondary sources:

(b) For denial of payment, at the time of any action affecting the claim;

(c) For standard prior authorizations that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested, the PHP must provide Notice of Action as expeditiously as the Division member's health condition requires and within 14 calendar days following receipt of the request for service, except that:

(A) The PHP may have a possible extension of up to 14 additional calendar days if the Division member or the provider requests the extension; or if the PHP justifies (to the Division upon request) a need for additional information and how the extension is in the Division member's interest;

(B) If the PHP extends the timeframe, in accordance with subsection (A) of this section, it ~~must~~ shall give the Division member written notice of the reason for the decision to extend the timeframe and inform the

Division member of their right to file a grievance if he or she disagrees with that decision. The PHP must issue and carry out its prior authorization determination as expeditiously as the Division member's health condition requires and no later than the date the extension expires;

| (d) For prior authorization decisions not reached within the timeframes specified in subsection (c) of this section, (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire;

| (e) For expedited prior authorizations, within the timeframes specified in OAR 410-141-0265.

Stat. Auth.: ORS 409.110, 413.042 & 414.065

Stats. Implemented: ORS 414.065

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**410-141-3260**

**—Grievance System: Grievances, Appeals and Contested Case Hearings**

(1) This rule applies to requirements related to the grievance system, which includes appeals, contested case hearings, and grievances. For purposes of this rule and OAR 410-141-3261 through 410-141-3264, references to member means a member, member's representative and the representative of a deceased member's estate.

(2) The CCO must establish and have a Division approved process and written procedures, for the following:

(a) Member rights to appeal and request a CCO's review of an action;

(b) Member rights to request a contested case hearing on a CCO action under the Administrative Procedures Act; and

(c) Member rights to file a grievance for any matter other than an appeal or contested case hearing;

(d) An explanation of how CCOs shall accept, process, and respond to appeals, hearing requests, and grievances;

(e) Compliance with grievance system requirements as part of the state quality strategy and to monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure consistent response to complaints of violations of consumer right and protections.

(3) Upon receipt of a grievance or appeal, the CCO must:

(a) Acknowledge receipt to the member;

(b) Give the grievance or appeal to staff with the authority to act upon the matter;

(c) Obtain documentation of all relevant facts concerning the issues;

(d) Ensure that staff making decisions on the grievance or appeal are:

(A) Not involved in any previous level of review or decision-making; and

(B) Health care professionals, as defined in OAR 410-120-0000, with appropriate clinical expertise in treating the member's condition or disease if the grievance or appeal involves clinical issues or if the member requests an expedited review.

(4) The CCO must analyze all grievances, appeals, and hearings in the context of quality improvement activity pursuant to OAR 410-141-3200 and 410-141-3260.

(5) CCOs must keep all healthcare information concerning a member's request confidential, consistent with appropriate use or disclosure as the terms treatment, payment, or CCO health care operations, are defined in 45 CFR 164.501.

(6) The following pertains to release of a member's information:

(a) The CCO and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal or hearing may use this information without the member's signed release for purposes of:

- (A) Resolving the matter; or
- (B) Maintaining the grievance or appeals log.

(b) If the CCO needs to communicate with other individuals or entities, not listed in subsection (a), to respond to the matter, the CCO must obtain the member's signed release and retain the release in the member's record.

(7) The CCO must provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes, but is not limited to:

(a) Assistance from qualified community health workers, qualified peer wellness specialists or personal health navigators to participate in processes affecting the member's care and services;

(b) Free interpreter services;

(c) Toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and

(d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.

(8) The CCO and its participating providers may not:

(a) Discourage a member from using any aspect of the grievance, appeal, or hearing process;

(b) Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or

(c) Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.

(9) In all CCO administrative offices and in those physical, behavioral, and oral health offices where the CCO has delegated response to the appeal, hearing request or grievance, the CCO must have the following forms available:

(a) OHP Complaint Form (OHP 3001);

(b) Appeal forms;

(c) Hearing request form, (DHS 443) and Notice of Hearing Rights (DMAP 3030); or

(d) The Division of Medical Assistance Programs Service Programs-Denial Appeal and Hearing Request form (DMAP 42343302), or approved facsimile.

(10) A member's provider:

(a) Acting on behalf of and with written consent of the member, may file an appeal;

(b) May not act as the member's authorized representative for requesting a hearing or filing a grievance.

(11) The CCO and its participating providers must cooperate with the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsman and hearing representatives in all activities related to member appeals, hearing requests, and grievances including providing all requested written materials.

(12) If the CCO delegates the grievance and appeal process to a subcontractor, the CCO must:

(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3261 through 410-141-3264;

(b) Monitor the subcontractor's performance on an ongoing basis;

(c) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and

(d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.

(13) CCO's must maintain yearly logs of all appeals and grievances for seven calendar years with the following requirements:

(a) The logs must contain the following information pertaining to each member's appeal or grievance:

(A) The member's name, ID number, and date the member filed the grievance or appeal;

(B) Documentation of the CCO's review, resolution, or disposition of the matter, including the reason for the decision and the date of the resolution or disposition;

(C) Notations of oral and written communications with the member; and

(D) Notations about appeals and grievances the member decides to resolve in another way if the CCO is aware of this.

(b) For each calendar year, the logs must contain the following aggregate information:

(A) The number of actions; and

(B) A categorization of the reasons for and resolutions or dispositions of appeals and grievances.

(14) The CCO must review the log monthly for completeness and accuracy, which includes but is not limited to timeliness of documentation and compliance with procedures.

(15) A member or a member's provider may request an expedited resolution of an appeal or a contested case hearing if the member or provider believes taking the standard time of resolution could seriously jeopardize the member's:

(a) Life, health, mental health or dental health; or

(b) Ability to attain, maintain or regain maximum function.

(16) A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending:

(a) To be entitled to continuing benefits, the member must complete a hearing request or request for appeal, requesting continuing benefits, no later than:

(A) The tenth day following the date of the notice or the notice of appeal resolution; and

(B) The effective date of the action proposed in the notice, if applicable.

(b) In determining timeliness under section (3)(a) of this rule, delay for good cause, as defined in OAR 137-002-0528, is not counted;

(c) The benefits must be continued until:

- (A) A final appeal resolution resolves the appeal, unless the member requests a hearing with continuing benefits; no later than ten days following the date of the notice of appeal resolution;
- (B) A final order resolves the contested case;
- (C) The time period or service limits of a previously authorized service have been met; or
- (D) The member withdraws the request for hearing.

(17) The CCO shall review and report to the Authority complaints that raise issues related to racial or ethnic background, gender, religion, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status and other identity factors for consideration in improving services for health equity.

(18) If a CCO receives a complaint or grievance related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one CCO to another CCO for reasons defined in OAR 410-141-3080 (15) the CCO shall log the complaint/grievance and work with the receiving/sending CCO to ensure continuity of care during the transition.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.610 – 414.685