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TEMPORARY ADMINISTRATIVE ORDER

INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 14-2018

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED
03/08/2018 9:29 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Annual Updates; Relative Value Unit (RVU) Weight; Clinical Lab, ASC

EFFECTIVE DATE: 03/08/2018 THROUGH 09/03/2018

AGENCY APPROVED DATE: 03/06/2018

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NEED FOR THE RULE(S):

The Health Services Division (Division) General Rules, administrative rules govern payments for services provided to certain Medicaid eligible clients. The Division needs to amend OAR 410-120-1340 to implement the annual updates by the Centers for Medicare and Medicaid (CMS) Relative Value Unit (RVU) weights for physician services, Clinical Lab, and Ambulatory Surgical Centers.

JUSTIFICATION OF TEMPORARY FILING:

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, fee-for-service providers, and CCOs. These rules need to be adopted promptly so that the Authority may pay updated 2017 fee-for-service rates for medical surgical services.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Federal register, Vol. 82, No.219 published November 15, 2017
https://www.gpo.gov/fdsys/pkg/FR-2017-11-15/pdf/2017-23953.pdf

AMEND: 410-120-1340

RULE TITLE: Payment

RULE SUMMARY: The Health Services Division (Division) General Rules, administrative rules govern payments for services provided to certain Medicaid eligible clients. The Division needs to amend OAR 410-120-1340 to implement the annual updates by the Centers for Medicare and Medicaid (CMS) Relative Value Unit (RVU) weights for physician services, Clinical Lab, and Ambulatory Surgical Centers.

RULE TEXT:
(1) The Health Systems Division (Division) shall make payment only to the enrolled provider (see OAR 410-120-1260) who actually performs the service or to the provider's enrolled billing provider for covered services rendered to eligible clients.
(2) Division reimbursement for services may be subject to review prior to reimbursement.

(3) The Division that is administering the program under which the billed services or items are provided sets fee-for-service (FFS) payment rates.
(4) The Division uses FFS payment rates in effect on the date of service that are the lesser of:
(a) The amount billed;
(b) The Division maximum allowable amount or;
(c) Reimbursement specified in the individual program provider rules.
(5) The amount billed may not exceed the provider's "usual charge" (see definitions).
(6) The Division's maximum allowable rate setting process uses the following methodology for:
(a) Relative Value Unit (RVU) weight-based rates: For all CPT/HCPCS codes assigned an RVU weight, the 2018 Total RVU weights published in the Federal Register, Vol. 82, November 15, 2017, to be effective for dates of services on or after January 1, 2018:
(A) For professional services not typically performed in a facility, the Non-Facility Total RVU weight;
(B) For professional services typically performed in a facility, the Facility Total RVU weight;
(C) The Division applies the following conversion factors:
(i) $40.79 for labor and delivery codes (59400-59622);
(ii) $27.82 for Oregon primary care providers. A current list of primary care CPT, HCPCs, and provider specialty codes is available at http://www.oregon.gov/oha/healthplan/Pages/providers.aspx
(iii) $25.48 for all remaining RVU weight based CPT/HCPCS codes.
(D) Rate calculation: Effective January 1, 2018, the Division shall calculate rates for each RVU weight-based code using statewide Geographic Practice Cost Indices (GPCIs) as follows:
(i) Work RVU) X (Work GPCI of 1) + (Practice Expense RVU) X (Practice GPCI of 0.974) + (Malpractice RVU) X (Malpractice GPCI of 0.783);
(ii) Sum in paragraph (D)(i) multiplied by the applicable conversion factor in paragraph (C).
(b) Non RVU based rates:
(A) $20.78 is the base rate for anesthesia service codes 00100-01996. The rate is based on per unit of service;
(B) Clinical lab codes are priced at 70 percent of the 2018 Medicare clinical lab fee schedule;
(C) All approved Ambulatory Surgical Center (ASC) procedures are reimbursed at 80 percent of the 2018 Medicare fee schedule;
(D) Physician administered drugs billed under a HCPCS code are based on Medicare's published reimbursement rate (Average Sales Price (ASP) plus six percent). When no ASP rate is listed, the rate shall be based upon the Wholesale Acquisition Cost (WAC). If no WAC is available, then the rate shall be reimbursed at Acquisition Cost. Pricing information for WAC is provided by First Databank. These rates may change periodically based on drug costs;
(E) All procedures used for vision materials and supplies are based on contracted rates that include acquisition cost plus shipping and handling;
(F) Individual provider rules may specify reimbursement rates for particular services or items.
(7) The rates in section (6) are updated periodically and posted on the Authority web site at http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx.
(8) The Division reimburses inpatient hospital service under the DRG methodology, unless specified otherwise in the Hospital Services program administrative rules (chapter 410, division 125). Reimbursement for services, including claims paid at DRG rates, may not exceed any upper limits established by federal regulation.
(9) The Division reimburses all out-of-state hospital services at Oregon DRG or FFS rates as published in the Hospital Services program rules (chapter 410, division 125) unless the hospital has a contract or service agreement with the Division to provide highly specialized services.
(10) Payment rates for in-home services provided through Department of Human Services (Department) Aging and People with Disabilities (APD) may not exceed the costs of nursing facility services unless the criteria in OAR 411-027-0020 have been met.
(11) The Division sets payment rates for out-of-state institutions and similar facilities such as skilled nursing care

facilities and psychiatric and rehabilitative care facilities at a rate that is:
(a) Consistent with similar services provided in the State of Oregon; and
(b) The lesser of the rate paid to the most similar facility licensed in the State of Oregon or the rate paid by the Medical Assistance Programs in that state for that service; or
(c) The rate established by APD for out-of-state nursing facilities.
(12) The Division may not make payment on claims that have been assigned, sold, or otherwise transferred or when the billing provider, billing agent, or billing service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a provider for accounts receivable.
(13) The Division may not make a separate payment or copayment to a nursing facility or other provider for services included in the nursing facility's all-inclusive rate. The following services are not included in the all-inclusive rate (OAR 411-070-0085) and may be reimbursed separately:
(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services program administrative rules (chapter 410, division 121) and Home Enteral/Parenteral Nutrition and IV Services program administrative rules (chapter 410, division 148);
(b) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the appropriate program administrative rules (chapter 410, division 129 and 131);
(c) Continuous oxygen that exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122);
(d) Influenza immunization serum as described in the Pharmaceutical Services program administrative rules (chapter 410, division 121);
(e) Podiatry services provided under the rules in the Medical-Surgical Services program administrative rules (chapter 410, division 130);
(f) Medical services provided by a physician or other provider of medical services, such as radiology and laboratory, as outlined in the Medical-Surgical Services program rules (chapter 410, division 130);
(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122).
(14) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSA's). A separate payment may not be made for services included in the core package of services as outlined in chapter 410, division 142.
(15) For payment for Division clients with Medicare and full Medicaid:
(a) The Division limits payment to the Medicaid allowed amount, less the Medicare payment, up to the Medicare co-insurance and deductible, whichever is less. The Division's payment may not exceed the co-insurance and deductible amounts due;
(b) The Division pays the allowable rate for covered services that are not covered by Medicare.
(16) For clients with third-party resources (TPR), the Division pays the allowed rate less the TPR payment but not to exceed the billed amount.
(17) The Division payments including contracted PHP or CCO payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For the Division, payment in full includes:
(a) Zero payments for claims when a third party or other resource has paid an amount equivalent to or exceeding Division allowable payment; and
(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain payment authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual provider rules.
(18) Payment by the Division does not restrict or limit the Authority or any state or federal oversight entity's right to review or audit a claim before or after the payment. Claim payment may be denied or subject to recovery if medical review, audit, or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care or medical appropriateness of the care or payment.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.033, 414.065, 414.095, 414.727, 414.728, 414.742, 414.743