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PERMANENT ADMINISTRATIVE RULES

Oregon Health Authority, Division of Medical Assistance Programs	410
Agency and Division	Administrative Rules Chapter Number
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Upon filing.	
Adopted on	
11/01/2013	
Effective date	

RULE CAPTION

Related to client appeals/hearings, and provider requirements related to billing clients for non-covered services

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND: 410-120-1280, 410-120-1400, 410-120-1860

REPEAL:

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 413.042, 414.065, 183.341

Other Auth.:

Stats. Implemented: ORS 414.025, 414.065, 414.085, 414.019, 414.055, 183.411 &" 183.470

RULE SUMMARY

Rules are amended to require providers to review with and have OHP clients sign a new OHP Client Agreement to Pay for Health Services form, DMAP 3165, or facsimile containing the elements of the DMAP 3165, before providing and charging clients

for non-covered services. Rules are further revised to allow for use of a new Medical Assistance Service Denial Appeal and Hearing Request form, or Division approved facsimile, to be used in place of the MSC 443 and DMAP 3030 forms; change the standard for client failure to meet timely filing/actions from 'circumstances beyond the control of the client' to 'good cause;' more directly link that failure to comply with policies outlined in 410-120-1280 may be cause for provider sanctions; and to make clarity and housekeeping revisions.

Rhonda Bussek

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10-31-13

Authorized Signer

Printed Name

Date

Authorization Page replaces the ink signature on paper filings. Have your authorized signer sign and date, then scan and attach it to your filing. You must complete this step before submitting your Permanent and Temporary filings.

410-120-1280 Billing

RULE COMPLETELY REWRITTEN

(1) A provider enrolled with the Authority or providing services to a client in a CCO or PHP under the Oregon Health Plan (OHP) must not seek payment, from the client for any services covered by Medicaid fee-for-service or through contracted health care plans:

(a) A client cannot be billed for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Division;

(b) A client cannot be billed for services or treatments that have been denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.).

(2) For Medicaid covered services the provider must not bill the Division more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Division Program rules.

(3) Providers shall only bill a client or a financially responsible relative or representative of that client in the following situations:

(a) For any applicable coinsurance, copayments and deductibles expressly authorized in OAR chapter 410, division 120, OAR chapter 410, division 141, or any other individual Division Program rules;

(b) The client did not inform the provider of their OHP coverage, enrollment in a prepaid health plan (PHP) or coordinated care organization (CCO), or third party insurance coverage at the time of or after a service was provided, therefore, the provider could not bill the appropriate payer for reasons including, but not limited to, the lack of prior authorization, or the time limit to submit the claim for payment has passed. The provider must verify eligibility, pursuant to OAR 410-120-1140, and document attempts to obtain coverage information prior to billing the client;

(c) The client became eligible for benefits retroactively but did not meet all of the other criteria required to receive the service);

(d) A third party payer made payments directly to the client for services provided;

(e) The client has a limited benefit package: Citizen Alien Waived Emergency Medical Program (CWM) may be billed for services that are not benefits of those programs, refer to OAR 410-120-1210 for coverage. The provider must document that the client was informed in advance that the service or item would not be part of their benefit coverage by the Division. A DMAP 3165 is not required for these services;

(f) The client has requested a continuation of benefits during the contested case hearing process and the final decision was not in favor of the client. The client is responsible for any charges incurred for the denied service, on or after the effective date on the Notice of Action or Notice of Appeal Resolution. The provider must complete the DMAP 3165 pursuant to section (3)(h) of this rule before providing these services;

(g) In exceptional circumstances, a client may decide to privately pay for a covered service. In this situation, the provider may bill the client if the provider informs the client in advance of all of the following:

(A) The requested service is a covered service, and the appropriate payer (the Division, PHP, CCO or third party payer) would pay the provider in full for the covered service; and

(B) The estimated cost of the covered service, including all related charges, the amount that the appropriate payer would pay for the service, and that the provider cannot bill the client for an amount greater than the amount the appropriate payer would pay; and

(C) That the client knowingly and voluntarily agrees to pay for the covered service;

(D) The provider documents in writing, signed by the client or the client's representative, the provider gave the client the information described in (3)(g)(A-C); the client had an opportunity to ask questions, obtain additional information and consult with the client's caseworker or client representative; and the client agreed to privately pay for the service by signing an agreement incorporating all of the information described above. The client must be given a copy of the signed agreement. A provider shall not submit a claim for payment for covered services to the Division or to the client's PHP, CCO or third party payer that is subject to such agreement.

(h) A provider may bill a client for services that are not covered by the Division, PHP, or CCO (see definition of non-covered services). Before providing the non-covered service, the client must sign the provider-completed Agreement to Pay (DMAP 3165), or a facsimile containing all of the information and elements of the DMAP 3165, as shown in Table 3165 of this rule. The completed DMAP 3165, or facsimile, is valid only if the estimated fee does not change and the service is scheduled within 30 days of the client's signature. Providers must make a copy of the completed DMAP 3165, or facsimile, available to the Division or applicable PHP or CCO upon request.

(4) Code Set requirements:

(a) Federal Code Set requirements (45 CFR 162) apply to all Medicaid Code Set requirements, including the use of diagnostic or procedure codes for prior authorization, claims submissions and payments. Code Set has the meaning established in 45 CFR 162.103 and it includes the codes and the descriptors of the codes. Federal Code Set requirements are mandatory and the Division lacks any authority to delay or alter their

application or effective dates as established by the U.S. Department of Health and Human Services;

(b) The Division will adhere to the Code Set requirements in 45 CFR 162.1000 — 162.1011;

(c) Periodically, the Division will update its provider rules and tables to conform to national codes. In the event of an alleged variation between a Division-listed code and a national code, the Division will apply the national code in effect on the date of request or date of service;

(d) Only codes with limitations or requiring prior authorization are noted in rules. National Code Set issuance alone should not be construed as coverage, or a covered service by the Division;

(e) The Division adopts by reference the National Code Set revisions, deletions, and additions issued and published by the American Medical Association (Current Procedural Terminology — CPT) and on the CMS website (Healthcare Common Procedural Coding System — HCPCS). This code adoption should not be construed coverage, or a covered service by the Division.

(5) Claims:

(a) Upon submission of a claim to the Division for payment, the provider agrees that it has complied with all Division Program rules. Submission of a claim, however, does not relieve the provider from the requirement of a signed provider agreement;

(b) A provider enrolled with the Division must bill using the Authority assigned provider number, in addition to the National Provider Identification (NPI) number, if the NPI is available, pursuant to 410-120-1260;

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

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

(e) Must be for services provided within the provider's licensure or certification;

(f) Must be submitted after (unless specified otherwise in the Division's individual Program rules):

(A) Delivery of service; or

(B) Dispensing, shipment or mailing of the item.

(g) It is the responsibility of the provider to submit true and accurate information when billing the Division. Use of a billing provider does not abrogate the performing provider's responsibility for the truth and accuracy of submitted information;

(h) A claim is considered a valid claim only if all required data is entered on or attached to the claim form. See the appropriate provider rules and supplemental information for specific instructions and requirements;

(i) A provider or its contracted agency (including billing providers) shall not submit or cause to be submitted:

(A) Any false claim for payment;

(B) Any claim altered in such a way as to result in a payment for a service that has already been paid;

(C) Any claim upon which payment has been made or is expected to be made by another source unless the amount paid or to be paid by the other party is clearly entered on the claim form;

(D) Any claim for furnishing specific care, item(s), or service(s) that have not been provided.

(j) The provider is required to submit an Individual Adjustment Request, or to refund the amount of the overpayment, on any claim where the provider identifies an overpayment made by the Division;

(k) A provider who, after having been previously warned in writing by the Division or the Department of Justice about improper billing practices, is found to have continued such improper billing practices and has had an opportunity for a contested case hearing, shall be liable to the Division for up to triple the amount of the Division established overpayment received as a result of such violation.

(6) Diagnosis code requirement:

(a) A primary diagnosis code is required on all claims, using the HIPAA nationally required diagnosis Code Set, unless specifically excluded in individual Division Program rules;

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

(c) Hospitals are always required to bill using the 5th digit, in accordance with methodology used in the Medicare Diagnosis Related Groups.

(7) Procedure code requirement:

(a) For claims requiring a procedure code the provider must bill as instructed in the appropriate Division Program rules and must use the appropriate HIPAA procedure Code Set such as CPT, HCPCS, ICD-9-CM, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided;

(b) For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the client's condition and the service(s) provided. Providers must use the ICD-9-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual Division Program rules. Hospitals must follow national coding guidelines;

(c) When there is no appropriate descriptive procedure code to bill the Division, the provider must use the code for "unlisted services." Instructions on the specific use of unlisted services are contained in the individual provider rules. A complete and accurate description of the specific care, item, or service must be documented on the claim;

(d) Where there is one CPT, CDT or HCPCS code that according to CPT, CDT and HCPCS coding guidelines or standards, describes an array of services the provider must bill the Division using that code rather than itemizing the services under multiple codes. Providers must not "unbundle" services in order to increase the Division payment.

(8) Third party Liability (TPL):

(a) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Division will be the payer of last resort;

(b) Providers must make reasonable efforts to obtain payment first from other resources. For the purposes of this rule "reasonable efforts" include determining the existence of insurance or other resources on each date of service by:

(A) Using an insurance database such as Electronic Verification System (EVS) available to the provider;

(B) Using the Automated Voice Response (AVR) or secure provider web portal on each date of service and at the time of billing.

(c) Except as noted in (8) (d) (A through E) below, when third party coverage is known to the provider, prior to billing the Division the provider must:

(A) Bill the TPL; and

(B) Except for pharmacy claims billed through the Division's point-of-sale system the provider must have waited 30 days from submission date of a clean claim and have not received payment from the third party; and

(C) Comply with the insurer's billing and authorization requirements; and

(D) Appeal a denied claim when the service is payable in whole or in part by an insurer.

(d) In accordance with federal regulations the provider must bill the TPL prior to billing the Division, except under the following circumstances:

(A) The covered health service is provided by an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID);

(B) The covered health service is provided by institutional services for the mentally and emotionally disturbed;

(C) The covered health services are prenatal and preventive pediatric services;

(D) Services are covered by a third party insurer through an absent parent where the medical coverage is administratively or court ordered;

(E) When another party may be liable for an injury or illness (see definition of Liability Insurance), the provider may bill the insurer or liable party or place a lien against a settlement or the provider may bill the Division. The provider may not both place a lien against a settlement and bill the Division. The provider may withdraw the lien and bill the Division within 12 months of the date of service. If the provider bills the Division the provider must accept payment made by the Division as payment in full.

(e) The provider must not return the payment made by the Division in order to accept payment from a liability settlement or liability insurer or place a lien against that settlement:

(A) In the circumstances outlined in (8)(d)(A through E) above, the provider may choose to bill the primary insurance prior to billing the Division. Otherwise, the Division will process the claim and, if applicable, will pay the Division allowable rate for these services and seek reimbursement from the liable third party insurance plan;

(B) In making the decision to bill the Division the provider should be cognizant of the possibility that the third party payer may reimburse the service at a higher rate than the Division, and that, once the Division makes payment no additional billing to the third party is permitted by the provider.

(f) The provider may bill the Division directly for services that are never covered by Medicare or another insurer on the appropriate form identified in the relevant provider rules. Documentation must be on file in the provider's records indicating this is a non-

covered service for purposes of Third Party Resources. See the individual provider rules for further information on services that must be billed to Medicare first;

(g) Providers are required to submit an Individual Adjustment Request showing the amount of the third party payment or to refund the amount received from another source within 30 days of the date the payment is received. Failure to submit the Individual Adjustment Request within 30 days of receipt of the third party payment or to refund the appropriate amount within this time frame is considered concealment of material facts and grounds for recovery and/or sanction:

(A) When a provider receives a payment from any source prior to the submission of a claim to the Division, the amount of the payment must be shown as a credit on the claim in the appropriate field;

(B) Any provider who accepts third party payment for furnishing a service or item to a Division client after having billed the Division, shall:

(i) Submit an Individual Adjustment Request indicating the amount of the third party payment. Follow instructions in the individual Division Program rules and supplemental billing; or

(ii) When the provider has already accepted payment from the Division for the specific service or item, the provider shall make direct payment of the amount of the third party payment to the Division. The check to repay the Division shall include the reason the payment is being made and either:

(I) An Individual Adjustment Request which identifies the original claim, name and number of the client, date of service and item(s) or service(s) for which the repayment is made; or

(II) A copy of the Remittance Advice showing the original Division payment.

(C) Any provider who accepts payment from a client, or client's representative, and is subsequently paid for the service by the Division, shall reimburse the client, or their representative, the full amount of their payment.

(h) The Division reserves the right to make a claim against any third party payer after making payment to the provider of service. The Division may pursue alternate resources following payment if it deems this a more efficient approach. Pursue alternate resources includes, but is not limited to, requesting the provider to bill the third party and to refund the Division in accordance with this rule;

(i) For services rendered to a Medicare and Medicaid dual eligible client, the Division may request the provider to submit a claim for Medicare payment and the provider must honor that request. Under federal regulation, a provider agrees not to charge a beneficiary (or the state as the beneficiary's subrogee) for services for which a provider

failed to file a timely claim (42 CFR 424) with Medicare despite being requested to do so;

(j) If Medicare is the primary payer and Medicare denies payment, Medicare appeals must be timely pursued and Medicare denial must be obtained prior to submitting the claim for payment to Division. Medicare denial on the basis of failure to submit a timely appeal may result in the Division reducing from the amount of the claim any amount the Division determines could have been paid by Medicare.

(9) Full use of alternate resources:

(a) The Division will generally make payment only when other resources are not available for the client's medical needs. Full use must be made of reasonable alternate resources in the local community;

(b) Except as provided in subsection (10) of this rule, alternate resources may be available:

(A) Under a federal or state worker's compensation law or plan;

(B) For items or services furnished by reason of membership in a prepayment plan;

(C) For items or services provided or paid for directly or indirectly by a health insurance plan or as health benefits of a governmental entity, such as:

(i) Armed Forces Retirees and Dependents Act (CHAMPVA);

(ii) Armed Forces Active Duty and Dependents Military Medical Benefits Act (CHAMPUS); and

(iii) Medicare Parts A and B.

(D) To residents of another state under that state's Title XIX or state funded medical assistance programs; or

(E) Through other reasonably available resources.

(10) Exceptions:

(a) Indian Health Services or Tribal Health Facilities. Pursuant to 42 CFR 136.61 subpart G and the Memorandum of Agreement in OAR 310-146-0000, Indian Health Services facilities and tribal facilities operating under Public Law 93, Section 638 agreement are payers of last resort, and are not considered an alternate resource or TPL;

(b) Veterans Administration. Veterans who are also eligible for Medicaid benefits are encouraged to utilize Veterans' Administration facilities whenever possible. Veterans' benefits are prioritized for service related conditions and as such are not considered an alternate or TPL.

(11) Table 120-1280 – TPR codes.

(12) Table – OHP Client Agreement to Pay for Health Services, DMAP 3165.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065 & 414.085

OHP Client Agreement to Pay for Health Services



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

Provider Section

① Health care services requested: _____

Procedure codes (CPT/HCPCS): _____

② Expected date(s) of service: _____

③ Condition being treated: _____

④ Estimated fees \$ _____ to \$ _____

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

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

Provider Name: _____ NPI: _____
 Provider Signature: _____ Date: _____

OHP Client Section

⑥ Client Name: _____ DOB: _____ Client ID#: _____

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

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

Client (or representative's) signature: _____ Date: _____
 If signed by the client's representative, print their name here: _____

⑧ Witness signature: _____ Date: _____

Witness name: _____

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

Client – Keep a copy of this form for your records

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

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

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

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

② **Request an Appeal and or Hearing**

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

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

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

Ask your provider if:

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

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

④ **Ask about reduced rates and discounts**

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

⑤ **Get a second opinion**

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

Additional costs

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

Questions?

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

Attention Provider – Relevant Oregon Administrative Rules (OARs)

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

http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_tofc.html

410-120-1400 Provider Sanctions

(1) The Authority recognizes two classes of provider sanctions, mandatory and discretionary, outlined in (3) and (4) respectively.

(2) Except as otherwise noted, the Authority will impose provider sanctions at the discretion of the Authority Director or the Administrator of the Division whose budget includes payment for the services involved.

(3) The Division of Medical Assistance Programs (Division) will impose mandatory sanctions and suspend the provider from participation in Oregon's medical assistance programs:

(a) When a provider of medical services has been convicted (as that term is defined in 42 CFR 1001.2) of a felony or misdemeanor related to a crime, or violation of Title XVIII, XIX, or XX of the Social Security Act or related state laws;

(b) When a provider is excluded from participation in federal or state health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services or from the Medicare (Title XVIII) program of the Social Security Act as determined by the Secretary of Health and Human Services. The provider will be excluded and suspended from participation with Division for the duration of exclusion or suspension from the Medicare program or by the Office of the Inspector General;

(c) If the provider fails to disclose ownership or control information required under 42 CFR 455.104 that is required to be reported at the time the provider submits a provider enrollment application or when there is a material change in the information that must be reported, or information related to business transactions required to be provided under 42 CFR 455.105 upon request of federal or state authorities.

(4) The Division may impose discretionary sanctions when the Division determines that the provider fails to meet one or more of the Division's requirements governing participation in its medical assistance programs. Conditions that may result in a discretionary sanction include, but are not limited to, when a provider has:

(a) Been convicted of fraud related to any federal, state, or locally financed health care program or committed fraud, received kickbacks, or committed other acts that are subject to criminal or civil penalties under the Medicare or Medicaid statutes;

(b) Been convicted of interfering with the investigation of health care fraud;

(c) Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(d) By actions of any state licensing authority for reasons relating to the provider's professional competence, professional conduct, or financial integrity either:

(A) Had his or her health care license suspended or revoked, or has otherwise lost such license; or

(B) Surrendered his or her license while a formal disciplinary proceeding is pending before such licensing authority.

(e) Been suspended or excluded from participation in any federal or state health care program for reasons related to professional competence, professional performance, or other reason;

(f) Billed excessive charges (i.e., charges in excess of the usual charge); furnished items or services substantially in excess of the Division client's needs or in excess of those services ordered by a medical provider or in excess of generally accepted standards or of a quality that fails to meet professionally recognized standards;

(g) Failed to furnish medically necessary services as required by law or contract with the Division if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the Division client;

(h) Failed to disclose required ownership information;

(i) Failed to supply requested information on subcontractors and suppliers of goods or services;

(j) Failed to supply requested payment information;

(k) Failed to grant access or to furnish as requested, records, or grant access to facilities upon request of the Division or the State of Oregon's Medicaid Fraud Unit conducting their regulatory or statutory functions;

(l) In the case of a Hospital, failed to take corrective action as required by the Division, based on information supplied by the Quality Improvement Organization to prevent or correct inappropriate admissions or practice patterns, within the time specified by the Division;

(m) Defaulted on repayment of federal or state government scholarship obligations or loans in connection with the provider's health profession education. The Division:

(A) Must have made a reasonable effort to secure payment;

(B) Must take into account access of beneficiaries to services; and

(C) Will not exclude a community's sole physician or source of essential specialized services.

(n) Repeatedly submitted a claim with required data missing or incorrect:

(A) When the missing or incorrect data has allowed the provider to:

(i) Obtain greater payment than is appropriate;

(ii) Circumvent prior authorization requirements;

(iii) Charge more than the provider's usual charge to the general public;

(iv) Receive payments for services provided to persons who were not eligible;

(v) Establish multiple claims using procedure codes that overstate or misrepresent the level, amount or type of health care provided.

(B) Does not comply with the requirements of OAR 410-120-1280.

(o) Failed to develop, maintain, and retain in accordance with relevant rules and standards adequate clinical or other records that document the medical appropriateness, nature, and extent of the health care provided;

(p) Failed to develop, maintain, and retain in accordance with relevant rules and standards adequate financial records that document charges incurred by a client and payments received from any source;

(q) Failed to develop, maintain and retain adequate financial or other records that support information submitted on a cost report;

(r) Failed to follow generally accepted accounting principles or accounting standards or cost principles required by federal or state laws, rules, or regulations;

(s) Submitted claims or written orders contrary to generally accepted standards of medical practice;

(t) Submitted claims for services that exceed that requested or agreed to by the client or the responsible relative or guardian or requested by another medical provider;

(u) Breached the terms of the provider contract or agreement. This includes failure to comply with the terms of the provider certifications on the medical claim form;

(v) Rebated or accepted a fee or portion of a fee or charge for a the Division client referral; or collected a portion of a service fee from the client, and billed the Division for the same service;

(w) Submitted false or fraudulent information when applying for a the Division assigned provider number, or failed to disclose information requested on the provider enrollment application;

(x) Failed to correct deficiencies in operations after receiving written notice of the deficiencies from the Division;

(y) Submitted any claim for payment for which payment has already been made by the Division or any other source unless the amount of the payment from the other source is clearly identified;

(z) Threatened, intimidated or harassed clients or their relatives in an attempt to influence payment rates or affect the outcome of disputes between the provider and the Division;

(aa) Failed to properly account for a Division client's Personal Incidental Funds; including but not limited to using a client's Personal Incidental Funds for payment of services which are included in a medical facility's all-inclusive rates;

(bb) Provided or billed for services provided by ineligible or unsupervised staff;

(cc) Participated in collusion that resulted in an inappropriate money flow between the parties involved, for example, referring clients unnecessarily to another provider;

(dd) Refused or failed to repay, in accordance with an accepted schedule, an overpayment established by the Division;

(ee) Failed to report to Division payments received from any other source after the Division has made payment for the service;

(ff) Failure to comply with the requirements listed in OAR 410-120-1280, Billing.

(5) A provider who has been excluded, suspended or terminated from participation in a federal or state medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, shall not submit claims for payment, either personally or through claims submitted by any billing

agent/service, billing provider or other provider, for any services or supplies provided under the medical assistance programs, except those services or supplies provided prior to the date of exclusion, suspension or termination.

(6) Providers must not submit claims for payment to the Division for any services or supplies provided by a person or provider entity that has been excluded, suspended or terminated from participation in a federal or state medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, except for those services or supplies provided prior to the date of exclusion, suspension or termination.

(7) When the provisions of subsections (5) or (6) are violated, the Division may suspend or terminate the billing provider or any individual performing provider within said organization who is responsible for the violation(s).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.019, 414.025 & 414.065

410-120-1860

Contested Case Hearing Procedures

(1) These rules apply to all contested case hearings provided by the Division of Medical Assistance Programs (Division) involving a client's health care benefits, except as otherwise provided in OAR 410-141-0263. The hearings are conducted in accordance with the Attorney General's model rules at 137-003-0501 and following. When the term "agency" is used in the Attorney General's model rules, it shall refer to the Division for purposes of this rule. Except for 137-003-0528(1)(a), the method described in 137-003-0520(8)-(10) is used in computing any period of time prescribed in this division of rules (OAR 410 division 120) applicable to timely filing of client requests for hearing. Due to operational conflicts, the procedures needing revision and the expense of doing so, 137-003-0528(1)(a), which allows hearing requests to be treated as timely based on the date of postmark, does not apply to Division contested cases.

(2) Medical provider appeals and administrative reviews involving the Division are governed by OAR 410-120-1560 through 410-120-1600.

(3) Complaints and appeals for clients requesting or receiving medical assistance from a Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) shall be governed exclusively by the procedures in OARs 410-141-3260 to 410-141-3262 and 410-141-0260 to 410-141-0262. This rule describes the procedures applicable when those clients request and are eligible for a Division contested case hearing.

(4) Contested Case Hearing Requests:

(a) A client has the right to a contested case hearing in the following situations upon the timely completion of a request for a hearing:

(A) The Authority acts to deny client services, payment of a claim, or to terminate, discontinue or reduce a course of treatment, or issues related to disenrollment in a CCO or PHP; or

(B) The right of a client to request a contested case hearing is otherwise provided by statute or rule, including OAR 410-141-0264 when a client of a PHP or 410-141-0364 when a client of a CCO may request a state hearing.

(b) To be timely, a request for a hearing is complete when the Division receives the Division approved appeal and hearing forms not later than the 45th day following the date of the decision notice;

(c) In the event a request for hearing is not timely, the Division will determine whether the client showed there was good cause, as defined in OAR 137-003-0501(7) for their failure to timely file the hearing request. In determining whether to accept a late hearing request, the Division requires the request to be supported by a written statement that

explains why the request for hearing is late. The Division may conduct such further inquiry as the Division deems appropriate. If the Division finds that the client has good cause for late filing, the Division will refer the case to the OAH for a contested case hearing. The following factual disputes will be referred to the OAH for a hearing:

(A) Whether the hearing request was received timely;

(B) Whether the client received the notice of action;

(C) The information included in the client's statement of good cause.

(d) In the event the claimant has no right to a contested case hearing on an issue, the Division may enter an order accordingly. The Division may refer a hearing request to the Office of Administrative Hearings for a hearing on the question of whether the claimant has a right to a contested case hearing;

(e) A client who requests a hearing shall be referred to as a claimant. The parties to a contested case hearing are the claimant and, if the claimant has requested a hearing about a decision of a CCO or PHP, the claimant's CCO or PHP;

(f) A client may be represented by any of the persons identified in ORS 183.458. A CCO or PHP that is a corporation may be represented by any of the persons identified in ORS 410.190.

(5) Expedited hearings:

(a) A claimant who feels his or her medical or dental problem cannot wait for the normal review process may be entitled to an expedited hearing;

(b) Expedited hearings are requested using Authority Form 443 or other Division approved appeal and/or hearing request forms;

(c) Division staff will request all relevant medical documentation and present the documentation obtained in response to that request to the Division Medical Director or the Medical Director's designee for review. The Division Medical Director or the Medical Director's designee will decide if the claimant is entitled to an expedited hearing within, as nearly as possible, two working days from the date of receiving the documentation applicable to the request;

(d) An expedited hearing will be allowed, if the Division Medical Director or the Medical Director's designee, determines that the claimant has a medical condition which is an immediate, serious threat to claimant's life or health and claimant has been denied a medical service.

(6) Informal conference:

(a) The Division hearing representative and the claimant, and their legal representative if any, may have an informal conference, without the presence of the Administrative law Judge (ALJ), to discuss any of the matters listed in OAR 137-003-0575. The informal conference may also be used to:

(A) Provide an opportunity for the Division and the claimant to settle the matter;

(B) Provide an opportunity to make sure the claimant understands the reason for the action that is subject of the hearing request;

(C) Give the claimant and the Division an opportunity to review the information that is the basis for that action;

(D) Inform the claimant of the rules that serve as the basis for the contested action;

(E) Give the claimant and the Division the chance to correct any misunderstanding of the facts;

(F) Determine if the claimant wishes to have any witness subpoenas issued for the hearing; and

(G) Give the Division an opportunity to review its action.

(b) The claimant may, at any time prior to the hearing date, request an additional informal conference with the Authority representative, which may be granted if the Authority representative finds, in his or her sole discretion, that the additional informal discussion will facilitate the hearing process or resolution of disputed issues;

(c) The Division may provide to the claimant the relief sought at any time before the Final Order is served;

(d) Any agreement reached in an informal conference shall be submitted to the ALJ in writing or presented orally on the record at the hearing.

(7) A claimant may withdraw a hearing request at any time. The withdrawal is effective on the date it is received by the Division or the ALJ, whichever is first. The ALJ will send a Final Order confirming the withdrawal to the claimant's last known address. The claimant may cancel the withdrawal up to the tenth calendar day following the date such an order is effective.

(8) Contested case hearings are closed to non-participants in the hearing; however, a client may choose to have another person present.

(9) Proposed and Final Orders:

(a) In a contested case, an ALJ assigned by the Office of Administrative Hearings will serve a proposed order on all parties and the Division, unless, prior to the hearing, the Division notifies the ALJ that a final order may be served. The proposed order issued by the ALJ will become a final order if no exceptions are filed within the time specified in subsection (b) unless the Division notifies the parties and the ALJ that the Division will issue the final order;

(b) If the ALJ issues a proposed order, a party adversely affected by the proposed order may file exceptions to the proposed order or present argument for the Division's consideration:

(A) The exceptions must be in writing and reach the Division not later than 10 working days after date the proposed order is issued by the ALJ;

(B) After receiving the exceptions, if any, the Division may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, the Authority will issue an amended proposed order.

(10) A hearing request is dismissed by order when neither the party nor the party's legal representative, if any, appears at the time and place specified for the hearing. The order is effective on the date scheduled for the hearing. The Division will cancel the dismissal order on request of the party upon the party being able to show good cause, as defined in OAR 137-003-0501(7), as to why they were unable to attend the hearing and unable to request a postponement.

(11) The final order is effective immediately upon being signed or as otherwise provided in the order. A final order resulting from the claimant's withdrawal of the hearing request is effective the date the claimant withdraws. When claimant fails to appear for the hearing and the hearing request is dismissed by final order, the effective date of the order is the date of the scheduled hearing.

(12) All contested case hearing decisions are subject to judicial review under ORS 183.482 in the Court of Appeals.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 183.341 & 413.042

Stats. Implemented: ORS 183.411 - 183.470, 414.025, 414.055 & 414.065