

Secretary of State  
Certificate and Order for Filing  
**PERMANENT ADMINISTRATIVE RULES**

I certify that the attached copies\* are true, full and correct copies of the PERMANENT Rule(s) adopted on [upon filing] by the  
Date prior to or same as filing date

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

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to become effective [ 11/1/12 ]. Rulemaking Notice was published in the [ 10/1/12 ] Oregon Bulletin.\*\*  
Date upon filing or later Month and Year

**RULE CAPTION**

Include use of CCOs where PHP is used as well as some readability revisions

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

**RULEMAKING ACTION**

List each rule number separately (000-000-0000)

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

**ADOPT:**

**AMEND:** OAR 410-120-0000, 410-120-0030, 410-120-0045, 410-120-1140, 410-120-1160, 410-120-1180, 410-120-1210, 410-120-1230, 410-120-1280, 410-120-1295, 410-120-1320, 410-120-1340, 410-120-1560, 410-120-1570, 410-120-1580, 410-120-1600, 410-120-1860, 410-120-1880

**REPEAL:** OAR 410-120-1340(T)

Stat. Auth.: ORS 183.341, 413.042 & 414.065

Other Auth.:

Stats. Implemented: ORS 183.411 - 183.470, 414.019, 414.025, 414.041, 414.047, 414.055, 414.065, 414.085, 414.115, 414.125, 414.135, 414.145, 414.705, 414.706, 414.707, 414.708, 414.710, 414.740, 414.743 & 409.010

**RULE SUMMARY**

The General Rules administrative rules govern Division payments for services to clients. The Division implemented Coordinated Care Organizations and promulgated rules effective August 1, 2012. The revisions to the General rules are to incorporate CCO wherever PHP's are currently referenced in order to be consistent with chapter 410 division 141 rules. There are also some non-substantive readability revisions that do not change any of the intent of the current rule.

Authorized Signer Printed name Date  
\*With this original, file one photocopy of certificate, one paper copy of rules listed in Rulemaking Actions, and electronic copy of rules. \*\*The Oregon Bulletin is published the 1st of each month and updates rules found in the OAR Compilation. For publication in Bulletin, rule and notice filings must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, when filings are accepted until 5:00 pm on the preceding workday. ARC 930-2005

## 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), 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, OAR 410-141-0300, and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 407 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) "Acupuncturist" means a person licensed to practice acupuncture by the relevant state licensing board.
- (3) "Acupuncture Services" means services provided by a licensed acupuncturist within the scope of practice as defined under state law.
- (4) "Acute" means a condition, diagnosis or illness with a sudden onset and that is of short duration.
- (5) "Acquisition Cost" means unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply or equipment, plus any shipping and/or postage for the item.
- (6) "Addiction and Mental Health Division (AMH)" means a division within the Authority that administers mental health and addiction programs and services.
- (7) "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.
- (8) "Administrative Medical Examinations and Reports" mean 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.
- (9) "Advance Directive" means an individual's instructions to an appointed individual specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.
- (10) "Adverse Event" means an undesirable and unintentional, though not unnecessarily unexpected, result of medical treatment.
- (11) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (DHS) that administers programs for seniors and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD)".
- (12) "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.
- (13) "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 individual.

(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).

(14) “Alternative Care Settings” mean 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.

(15) “Ambulance” means a specially equipped and licensed vehicle for transporting sick or injured persons which meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.

(16) “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).

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

(18) “American Indian/Alaska Native (AI/AN)” means a member of a federally recognized Indian tribe, band or group, 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.

(19) “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).

(20) “Ancillary Services” mean services supportive of or necessary for providing a primary service, such as, anesthesiology, which is an ancillary service necessary for a surgical procedure.

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

(22) “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.

(23) “Atypical Provider” means entity able to enroll as a billing provider (BP) or rendering provider for medical assistance programs related non-health care services but which does not meet the definition of health care provider for National Provider Identification (NPI) purposes.

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

(25) “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.

(26) “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.

- (27) “Benefit Package” means the package of covered health care services for which the client is eligible.
- (28) “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.
- (29) “Billing Provider (BP)” means a person, agent, business, corporation, clinic, group, institution, or other entity who submits claims to and/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.
- (30) “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).
- (31) “By Report (BR): means services designated, as BR require 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.
- (32) “Case Management Services” mean 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, chemical dependency and/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 which may include referrals to Allied Agencies.
- (33) “Children, Adults and Families Division (CAF)” means a division within the Department, responsible for administering self-sufficiency and child-protective programs.
- (34) “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.
- (35) “Chiropractor” means a person licensed to practice chiropractic by the relevant state licensing board.
- (36) “Chiropractic Services” mean services provided by a licensed chiropractor within the scope of practice, as defined under state law and Federal regulation.
- (37) “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).
- (38) “Claimant” means a person who has requested a hearing.
- (39) “Client” means an individual found eligible to receive OHP health services. “Client” is inclusive of members enrolled in PHPs, PCMs and CCOs.
- (40) “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.
- (41) “Clinical Social Worker” means a person licensed to practice clinical social work pursuant to State law.

- (42) "Clinical Record" means the medical, dental or mental health records of a client or member.
- (43) "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.
- (44) "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.
- (45) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.
- (46) "Contiguous Area Provider" means a provider practicing in a contiguous area.
- (47) "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.
- (48) "Co-Payments" mean 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).
- (49) "Cost Effective" means the lowest cost health care service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.
- (50) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.
- (51) "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.
- (52) "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.
- (53) "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.
- (54) "Dental Emergency Services" mean dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.
- (55) "Dental Services" mean services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist.
- (56) "Dentist" means a person licensed to practice dentistry pursuant to state law of the state in which he/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.
- (57) "Denturist" means a person licensed to practice denture technology pursuant to State law.

(56) “Denturist Services” mean services provided, within the scope of practice as defined under State law, by or under the personal supervision of a denturist.

(58) “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.

(59) “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.

(60) “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.

(61) “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.

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

(63) “Diagnosis Code” means as identified in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM), the primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rule(s). Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(64) “Diagnosis Related Group (DRG)” means a system of classification of diagnoses and procedures based on the ICD-9-CM.

(65) “Division of Medical Assistance Programs (Division)” means a 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.

(66) “Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)” mean 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.

(67) “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.

(68) “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.

(69) “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.

(70) “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.

(71) “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.

(72) “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)).

(73) “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.

(74) “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.

(75) “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)).

(76) “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.

(77) "Family Health Insurance Assistance Program (FHIAP)" means a program in which the State subsidizes premiums in the commercial insurance market for uninsured individuals and families with income below 185% of the Federal Poverty Level.

(78) "Family Planning Services" mean services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and which are intended to prevent pregnancy or otherwise limit family size.

(79 "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity which 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.

(80) "Fee-for-Service Provider" means a health care provider who is not reimbursed under the terms of a 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.

(81) "Flexible Service" means a service that is an alternative or addition to a service that is as likely or more likely to effectively treat the mental condition, chemical dependency condition, or physical condition as documented in the Member's Clinical Record. Flexible Services may include, but are not limited to: Respite Care, Partial Hospitalization, Subacute Psychiatric Care, Family Support Services, Parent Psychosocial Skills Development, Peer Services, and other non-Traditional Services identified.

(82) "Flexible Service Approach" means the delivery of any Coordinated Care Service in a manner or place different from the traditional manner or place of service delivery. A Flexible Service Approach may include delivering Coordinated Care Services at alternative sites such as schools, residential facilities, nursing facilities, Members' homes, emergency rooms, offices of DHS, OHA, other community settings; offering flexible clinic hours; offering Coordinated Care Services through outreach or a home-based approach; and using peers, paraprofessionals, Community Health Workers, Peer Wellness Specialists, or Personal Health Navigators who are Culturally Competent to engage difficult-to-reach Members.

(83) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(84) "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.

(85) "General Assistance (GA)" means medical assistance administered and funded 100% with State of Oregon funds through OHP.

(86) "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, Division uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.

(87) "Health Care Professionals" mean 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.

(88) “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.

(89) “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.

(90) “Health Maintenance Organization (HMO)” means a public or private health care organization which 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.

(91) “Health Plan New/noncategorical 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.

(92) “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.

(93) “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.

(94) “Home Health Agency” means a public or private agency or organization which has been certified by Medicare as a Medicare home health agency and which 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.

(95) “Home Health Services” mean 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.

(96) “Home Intravenous Services” mean 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.

(97) “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.

(98) “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 currently licensed by the Oregon Health Authority (Authority), Public Health Division.

(99) “Hospital” means a facility licensed by the Office of Public Health Systems as a general hospital which 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 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.

(100) "Hospital-Based Professional Services" mean 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.

(101) "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, inpatient, or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).

(102) "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.

(103) "Indian Health Care Provider" means an Indian health program or an urban Indian organization.

(104) "Indian Health Program" means any Indian Health Service (IHS) facility, any Federally recognized Tribe or Tribal organization, or any FQHC with a 638 designation.

(105) "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.

(106) "Indigent" means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602) indigent has the meaning: Individuals with out health insurance coverage, public or private and meet standards for indigence adopted by the federal government as defined in ORS 813.602 (5).

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

(108) "Inpatient Hospital Services" mean 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.)

(109) "Institutional Level of Income Standards (ILIS)" mean 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 the Mentally Retarded (ICF/MR) and individuals on ICF/MR waivers or eligibility for services under Seniors and People with Disabilities' (SPD) Home and Community Based Waiver.

(110) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing and/or hospital care for a period of 30 days or more.

(111) "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (including volumes 1, 2, and 3, as revised annually)" mean a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.

(112) "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, 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).

(113) “Laboratory Services” mean 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/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.

(114) “Licensed Direct Entry Midwife” means a practitioner who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery by the Public Health Division.

(115) “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.

(116) “Managed Care Organization (MCO)” means 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).

(117) “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, which address social, economic and nutritional factors. For more information refer to the Division’s Medical-Surgical Services Program administrative rules.

(118) “Medicaid” means a federal and state funded portion of the medical assistance programs established by Title XIX of the Social Security Act, as amended, administered in Oregon by the Authority.

(119) “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.

(120) “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.

(121) “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).

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

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

(124) “Medically Appropriate” means services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which 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 which can be safely provided to a Division client or Primary Care Manager (PCM) Member in the PHP's or PCM's judgment.

(125) "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 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; 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.

(126) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.

(127) "Medicheck for Children and Teens" mean services also known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. 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 Authorityclients and their parents or guardians effectively use them.

(128) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.

(129) "Mental Health Case Management" means services provided to CCO members who require assistance to ensure access to mental health benefits and services from local, regional or state allied agencies or other service providers. Services provided may include: advocating for the CCO member's treatment needs; providing assistance in obtaining entitlements based on mental or emotional disability; referring CCO members to needed services or supports; accessing housing or residential programs; coordinating services, including educational or vocational activities; and establishing alternatives to inpatient psychiatric services.

(130) " 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.

(131) "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.

(132) “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.

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

(134) “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..

(135) “Non-covered Services” mean 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.

(136) “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).

(137) “Nurse Anesthetist, C.R.N.A.” means a registered nurse licensed in the State of Oregon who is currently certified by the American Association of Nurse Anesthetists Council on Certification.

(138) “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.

(139) “Nurse Practitioner Services” mean services provided within the scope of practice of a Nurse Practitioner as defined under State law and by rules of the Board of Nursing.

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

(141) “Nursing Services” mean 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.

(142) “Nutritional Counseling” means counseling which takes place as part of the treatment of a person with a specific condition, deficiency or disease such as diabetes, hypercholesterolemia, or phenylketonuria.

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

(144) “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, 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.

(145) “Ombudsman Services” mean 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.

(146) “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.

(147) “Oregon Health Plan (OHP)” means the Medicaid and Children’s Health Insurance (CHIP) Demonstration Project which 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

(148) “Optometric Services” mean services provided, within the scope of practice of optometrists as defined under State law.

(149) “Optometrist” means a person licensed to practice optometry pursuant to State law.

(150) “Oregon Health Authority (Authority or OHA)” 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 OHA are the Public Health Division, the Addictions and Mental Health Division, and the Division of Medical Assistance Programs.

(151) “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.

(152) “Out-of-State Providers” mean 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.

(153) “Outpatient Hospital Services” mean 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.

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

(155) “Overpayment” means payment(s) made by Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.

(156) “Overuse” means use of medical goods or services at levels determined by Authority medical staff and/or medical consultants to be medically unnecessary or potentially harmful.

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

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

(159) "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.

(160) "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.

(161) "Pharmaceutical Services" mean services provided by a Pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within his/her scope of practice.

(162) "Pharmacist" means a person licensed to practice pharmacy pursuant to state law.

(163) "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.

(164) "Physical Therapist" means a person licensed by the relevant State licensing authority to practice Physical Therapy.

(165) "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 shall not include radiology or electrosurgery.

(166) "Physician" means a person licensed to practice medicine pursuant to state law of the state in which he/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.

(167) "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.

(168) "Physician Services" mean services provided, within the scope of practice as defined under state law, by or under the personal supervision of a physician.

(169) "Podiatric Services" mean services provided within the scope of practice of podiatrists as defined under state law.

(170) "Podiatrist" means a person licensed to practice podiatric medicine pursuant to state law.

(171) "Post-Payment Review" means review of billings and/or other medical information for accuracy, medical appropriateness, level of service or for other reasons subsequent to payment of the claim.

(172) "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 and/or certification.

(173) "Premium Sponsorship" means premium donations made for the benefit of one or more specified Division clients (See 410-120-1390).

(174) "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)

(175) “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.

(176) “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.

(177) “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.

(178) “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.

(179) “Private Duty Nursing Services” mean 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.

(180) “Provider” means an individual, facility, institution, corporate entity, or other organization which supplies health care 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(s) unless otherwise specified.

(181) “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) If such entity solely submits billings on behalf of providers and payments are made to each provider, then the entity is an agent. (See Subparts of Provider Organization).

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

(183) “Public Rates” mean 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.

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

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

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

- (187) “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.
- (188) “Radiological Services” mean 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.
- (189) “Recipient” means a person who is currently eligible for medical assistance (also known as a client).
- (190) “Recreational Therapy” means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).
- (191) “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.
- (192) “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.
- (193) “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.
- (194) “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.
- (195) “Representative” means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.
- (196) “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.
- (197) “Rural” means a geographic area that is 10 or more map miles from a population center of 30,000 people or less.
- (198) “Sanction” means an action against providers taken by the Authority in cases of fraud, misuse or abuse of Division requirements.
- (199) “School Based Health Service” means a health service required by an Individualized Education Plan (IEP) during a child's education program which addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.
- (200) “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.
- (201) “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.

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

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

(204) “Speech-Language Pathology Services” mean 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.

(205) “State Facility” means a Hospital or training center operated by the State of Oregon, which provides long-term medical or psychiatric care.

(206) “Subparts (of a Provider Organization)” mean 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, could be components of an organization or separate physical locations of an organization.

(207) “Subrogation” means Right of the State to stand in place of the client in the collection of third party resources (TPR).

(208) “Supplemental Security Income (SSI)” means a program available to certain aged and disabled persons which is administered by the Social Security Administration through the Social Security office.

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

(210) “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.

(211) “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.

(212) “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.

(213) “Third Party Liability (TPL) or Third Party Resource (TPR)” means a medical or financial resource which, under law, is available and applicable to pay for medical services and items for a Authority client.

(214) “Transportation” means Medical Transportation.

(215) “Type A Hospital” means a hospital identified by the Office of Rural Health as a Type A hospital.

(216) "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.

(217) "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.

(218) "Type B Hospital" means a hospital identified by the Office of Rural Health as a Type B hospital.

(219) "Urban" means a geographic area that is less than 10 map miles from a population center of 30,000 people or more.

(220) "Urgent Care Services" mean 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.

(221) "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% 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.

(222) "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.

(223) "Valid Claim" means an invoice received by the Division or the appropriate Authority/Department office for payment of covered health care services rendered to an eligible client which:

(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).

(224) "Vision Services" mean provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

Stat. Auth.: ORS 413.042 414.065

Stats. Implemented: ORS 414.065

410-120-0030

## Children's Health Insurance Program

(1) The Children's Health Insurance Program (CHIP) is a federal non-entitlement program. The Oregon Health Authority, Division of Medical Assistance Program (Division) administers two programs funded under CHIP in accordance with the Oregon Health Plan waiver and the CHIP state plan.

(a) CHIP: Provides health coverage for uninsured, low-income children who are ineligible for Medicaid;

(b) CHIP Prenatal care expansion program.

(2) The General Rules Program (OAR 410-120-0000 et. seq.) and Oregon Health Plan Program rules (OAR 410-141-0000 et. seq.) applicable to the Medicaid program are also applicable to the Authority's CHIP program.

(3) Children under 19 years of age, who meet the income limits, citizenship requirements and eligibility criteria for medical assistance established in OAR chapter 461 through the program acronym OHP-CHP, receive the OHP Plus benefit package (For benefits refer to OAR 410-120-1210).

(4) CHIP Prenatal care expansion coverage: for women not eligible for Medicaid at or below 185% of the FPL, with the benefit package identifier CWX:

(a) Receive the OHP Plus benefit package with limitations as described in subsection (d) of these rules;

(b) Reside in the following counties during pregnancy:

(A) Effective 4/1/08 Multnomah and Deschutes;

(B) Effective 10/1/09 Benton, Clackamas, Hood River and Jackson;

(C) Effective 1/1/11 Lane;

(D) Effective 7/1/11 Columbia, Crook, Douglas, Jefferson, Morrow, Union and Wasco;

(E) Effective 4/1/12 Umatilla.

(c) The day after pregnancy ends, eligibility for medical services is based on eligibility categories established in OAR chapter 461;

(d) The following services are not covered for this program:

(A) Postpartum care (except when included as part of a global delivery procedure);

(B) Sterilization;

(C) Abortion;

(D) Death with dignity services;

(E) Hospice.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

## Applications for Medical Assistance at Provider locations

(1) As prescribed in 42 CFR 435.904, the Oregon Health Authority (Authority) allows the Division of Medical Assistance Programs' (Division) enrolled providers the opportunity to assist patients applying to Medicaid and Children's Health Insurance Program (CHIP) at the provider's practice site. Once the provider is determined eligible by the Authority, providers will receive an approval letter, unique code for date-stamp, training requirements and other information.

(2) For purposes of this rule, the provider's practice will be referred to as a site. Sites can be, but are not limited, to the following:

- (a) Hospitals;
- (b) Federally qualified health centers/rural health clinics (FQHC/RHCs);
- (c) County health departments;
- (d) Adult and youth alcohol and drug treatment centers;
- (e) Tribal health clinics;
- (f) Family Planning clinics;
- (g) Other primary care clinics as approved by the Authority.

(3) The site shall send one or more employees to a mandatory Authority training session for application assistance certification before initiating the application assistance service. At least one trained employee must be a permanent employee of the site. Sites shall ensure that individuals performing application assistance are recertified at appropriate times as set forth by the Authority. For purposes of this rule, certified staff will be referred to as "application assistants."

(4) Application assistants provide Oregon Health Plan (OHP) application packets and enrollment support to their patients potentially eligible for Medicaid or CHIP. Sites are not under an obligation to provide OHP applications to individuals other than those they are providing care to. The application assistant shall establish a date of request for applicants by date stamping (stamp must adhere to standards accompanying the approval letter) the application in the appropriate place with the date the applicant requests an application. Once affixed to an application, the date can never be changed, altered or backdated. The date stamp must include the provider's assigned application assistant site code number, in addition to the date.

(5) The application assistant shall encourage applicants to provide accurate and truthful information, assist in completing the application and shall assure that the information contained on the application is complete. The application assistant shall not attempt to pre-determine applicant eligibility or make any assurances regarding the eligibility for OHP or CHIP programs.

(6) The application assistant shall provide information to applicants that will explain the OHP program and make an informed choice when selecting a health care provider/plan. Language (including sign language) translators must be available if requested by applicants in advance.

(a) The information given to the applicant shall, at a minimum, include an explanation of the significance of the date stamp, review of PHP or CCO plans that are available, provide unbiased PHP or CCO information, answer questions and assist in filling out application forms. The information provided at these sessions may include, but is not limited to the following:

- (A) OHP and "Healthy Kids" general eligibility criteria;

(B) Health plan choices, criteria and how to enroll in PHP or CCO for health, mental health, dental plans or primary care manager;

(C) Potential services that may or may not be covered by OHP.

(b) The application assistant is required to submit the applicant's eligibility verification (income statements, etc.) with the application to the OHP Central Branch. The application assistant may make copies of the documents.

(7) The site shall provide quarterly reports to the Authority on the number of stamped applications distributed each month of the quarter by the site. The quarterly report shall also list employees who have been certified by Authority staff during the quarter to perform the duties listed in OAR 410-120-0045.

(8) Providers, staff, contracted employees and volunteers are subject to all applicable provisions under General Rules OAR chapter 410, division 120.

(a) The application assistant shall treat all information they obtain for Medicaid as confidential and privileged communications. The application assistant shall not disclose such information without the written consent of the individual, his or her delegated authority, attorney, or responsible parent of a minor child or child's guardian. Nothing prohibits the disclosure of information in summaries, statistical or other form, which does not identify particular individuals;

(b) The Authority and sites will share information as necessary to effectively serve Medicaid eligible or potentially eligible individuals;

(c) Personally identifiable health information about applicants and Medicaid recipients will be subject to the transaction, security and privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the administrative rules there under. Sites will cooperate with the Authority in the adoption of policies and procedures for maintaining the privacy and security of records and for conducting transactions pursuant to HIPAA requirements.

(9) The Authority will be responsible for the following:

(a) The Authority will provide training to application assistants on Healthy Kids/OHP eligibility, application procedures and documentation requirements. The Authority will set dates and times for these additional training classes as needed, following changes in policy or procedure;

(b) The Authority will make available OHP application forms (in English, translated languages and alternative formats), OHP or CCO information and plan comparison charts, date stamp specifications, quarterly report templates and other necessary forms;

(c) The Authority will process all applications in accordance with Authority standards;

(d) The Authority will process completed OHP applications, which have satisfactory verification information, within the time requirements set forth in Authority policy. In the event of a change in policy, the time for completion of processing shall be changed to the new time requirements.

(10) The Authority will provide all necessary forms and applications as referenced above at no cost to the site. There are no monetary provisions in this rule for any payment for the performance of work by the site, except for those costs provided under OAR 410-147-0400 and 410-146-0460. However, the parties acknowledge the exchange and receipt of other valuable considerations in the spirit of cooperation to the benefit of all by collaborating and authorizing the performance of the work. The Authority does not guarantee a particular volume of business under these rules.

(11) The provider may terminate enrollment at any time as outlined in OAR 410-120-1260(15).

Stat. Auth.: 413.042

Statutes Implemented: 414.041

410-120-1140

#### Verification of Eligibility and Coverage

(1) To ensure Division reimbursement of services, providers are responsible to verify the following before rendering services:

- (a) Client eligibility: That the person is eligible on the date(s) services are rendered; and
- (b) Benefit coverage: that the person is enrolled in a benefit package that covers the services they plan to render. See OAR 410-120-1210 for services covered under each Division benefit package.

(2) Providers who do not verify eligibility and benefit coverage with the Division before serving a person assume full financial responsibility in serving that person .

(3) The following types of client identification (ID) only list the client's name, Oregon Medicaid ID number (prime number) and the date the ID was issued. They do not guarantee client eligibility or benefit coverage.

(a) The standard ID (called the Oregon Health ID, formerly the DHS Medical Care ID); printed on perforated paper the size of a business card;

(b) Replacement IDs (printed on regular printer paper in case of misplaced originals).

(4) When a person presents a standard or replacement ID, providers must verify client eligibility and benefit coverage as described part (1) of this rule through one of the following (see the Division General Rules Supplemental Information for instructions):

(a) The Division MMIS Provider Web portal;

(b) The Automated Voice Response (AVR) telephone system;

(c) Batch or real-time electronic data interchange (EDI) eligibility inquiry (270) and response (271) transactions;

(5) The client may also present with a Temporary Oregon Health ID (DMAP form 1086). This is a full page paper form that guarantees eligibility and benefit coverage for 7 days from the beginning dates of coverage entered in Part 1 of the form. This temporary ID is issued only if the client needs immediate care but their eligibility and coverage information is not yet available for verification as described in part (4) of this rule. Providers must honor the Temporary Oregon Health ID when presented within 7 days of the beginning date of coverage entered on the form.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065, 414.025 & 414.047

## Medical Assistance Benefits and Provider Rules

(1) Providers enrolled with and seeking reimbursement for services through the Division of Medical Assistance Programs (Division) are responsible for compliance with current federal and state laws and regulations governing Medicaid services and reimbursement, including familiarity with periodic law and rule changes. The Division's administrative rules are posted on the Oregon Health Authority (Authority) Web page for the division and its medical assistance programs. It is the provider's responsibility to become familiar with, and abide by, these rules.

(2) The following services are covered to the extent included in the Division client's benefit package of health care services, when medically or dentally appropriate and within the limitations established by the Division and set forth in the Oregon Administrative Rules (OARs) for each category of Medical Services:

(a) Acupuncture services, as described in the Medical-Surgical Services Program provider rules (OAR chapter 410, division 130);

(b) Administrative examinations, as described in the Administrative Examinations and Billing Services Program provider rules (OAR chapter 410, division 150);

(c) Alcohol and drug abuse treatment services:

(A) The Division covers alcohol and drug inpatient services for medical detoxification when provided in an acute care hospital and when hospitalization is considered medically appropriate;

(B) The Division does not cover residential level of care provided in an inpatient hospital setting for alcohol and drug abuse treatment;

(C) The Addictions and Mental Health Division (AMH) covers non-hospital alcohol and drug treatment services on a residential or outpatient basis through direct contracts with counties or providers. For information to access these services, contact the client's PHP or CCO if enrolled, the community mental health program (CMHP), an outpatient alcohol and drug treatment provider, the residential treatment program or AMH.

(d) Ambulatory surgical center services, as described in the Medical-Surgical Services Program provider rules (OAR 410 division 130);

(e) Anesthesia services, as described in the Medical-Surgical Services Program provider rules (OAR chapter 410, division 130);

(f) Audiology services, as described in the Speech-Language Pathology, Audiology and Hearing Aid Services Program provider rules (OAR chapter 410, division 129);

(g) Chiropractic services, as described in the Medical-Surgical Services Program provider rules (OAR chapter 410, division 130);

(h) Dental services, as described in the Dental/Denturist Services Program provider rules (OAR chapter 410, division 123);

(i) Early and periodic screening, diagnosis and treatment services (EPSDT, Medichex for children and teens), are covered for individuals under 21 years of age as set forth in the individual program provider rules. The Division may authorize services in excess of limitations established in the OARs when it is medically appropriate to treat a condition that is identified as the result of an EPSDT screening;

- (j) Family planning services, as described in the Medical-Surgical Services Program provider rules (OAR chapter 410, division 130);
- (k) Federally qualified health centers and rural health clinics, as described in the Federally Qualified Health Center and Rural Health Clinic Program provider rules (OAR chapter 410, division 147);
- (l) Home and community-based waiver services, as described in the Authority and the Department's OARs of Children, Adults and Families Division (CAF), Addictions and Mental Health Division (AMH), and Seniors and People with Disabilities Division (SPD);
- (m) Home enteral/parenteral nutrition and IV services, as described in the Home Enteral/Parenteral Nutrition and IV Services Program rules (OAR chapter 410, division 148), and related Durable Medical Equipment, Prosthetics, Orthotics and Supplies Program rules (OAR chapter 410, division 122) and Pharmaceutical Services Program rules (OAR chapter 410, division 121);
- (n) Home health services, as described in the Home Health Services Program rules (OAR chapter 410, division 127);
- (o) Hospice services, as described in the Hospice Services Program rules (OAR chapter 410, division 142);
- (p) Indian health services or tribal facility, as described in The Indian Health Care Improvement Act and its Amendments (Public Law 102-573), and the Division's American Indian/Alaska Native Program rules (OAR chapter 410, division 146);
- (q) Inpatient hospital services, as described in the Hospital Services Program rules (OAR chapter 410, division 125);
- (r) Laboratory services, as described in the Hospital Services Program rules (OAR chapter 410, division 125) and the Medical-Surgical Services Program rules (OAR chapter 410, division 130);
- (s) Licensed direct- entry midwife services, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130);
- (t) Maternity case management, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130);
- (u) Medical equipment and supplies, as described in the Hospital Services Program, Medical-Surgical Services Program, DMEPOS Program, Home Health Care Services Program, Home Enteral/Parenteral Nutrition and IV Services Program and other rules;
- (v) When a client's Benefit Package includes mental health, the mental health services provided will be based on the Oregon Health Services Commission's Prioritized List of Health Services.;
- (w) Naturopathic services, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130);
- (x) Nutritional counseling as described in the Medical/Surgical Services Program rules (OAR chapter 410, division 130);
- (y) Occupational therapy, as described in the Physical and Occupational Therapy Services Program rules (OAR chapter 410, division 131);
- (z) Organ transplant services, as described in the Transplant Services Program rules (OAR chapter 410, division 124);

- (aa) Outpatient hospital services, including clinic services, emergency department services, physical and occupational therapy services, and any other outpatient hospital services provided by and in a hospital, as described in the Hospital Services Program rules (OAR chapter 410, division 125);
- (bb) Physician, podiatrist, nurse Practitioner and licensed physician assistant services, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130);
- (cc) Physical therapy, as described in the Physical and Occupational Therapy and the Hospital Services Program rules (OAR chapter 410, division 131);
- (dd) Post-hospital extended care benefit, as described in OAR chapter 410, division 120 and 141 and Seniors and People with Disabilities (SPD) program rules;
- (ee) Prescription drugs, including home enteral and parenteral nutritional services and home intravenous services, as described in the Pharmaceutical Services Program (OAR chapter 410, division 121), the Home Enteral/Parenteral Nutrition and IV Services Program (OAR chapter 410, division 148) and the Hospital Services Program rules (OAR chapter 410, division 125);
- (ff) Preventive services, as described in the Medical-Surgical Services (OAR chapter 410, division 130) and the Dental/Denturist Services Program rules (OAR chapter 410, division 123) and prevention guidelines associated with the Health Service Commission's Prioritized List of Health Services (OAR 410-141-0520);
- (gg) Private duty nursing, as described in the Private Duty Nursing Services Program rules (OAR chapter 410, division 132);
- (hh) Radiology and imaging services, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130), the Hospital Services Program rules (OAR chapter 410, division 125), and Dental Services Program rules (OAR chapter 410, division 123);
- (ii) Rural health clinic services, as described in the Federally Qualified Health Center and Rural Health Clinic Program rules (OAR chapter 410, division 147);
- (jj) School-based health services, as described in the School-Based Health Services Program rules (OAR chapter 410, division 133);
- (kk) Speech and language therapy as described in the Speech-Language Pathology, Audiology and Hearing Aid Services Program rules (OAR chapter 410, division 129) and Hospital Services Program rules (OAR chapter 410, division 125);
- (ll) Transportation necessary to access a covered medical service or item, as described in the Medical Transportation Program rules (OAR chapter 410, division 136);
- (mm) Vision services as described in the Visual Services Program rules (OAR chapter 410, division 140).
- (3) Other Authority or Department Divisions, units or Offices, including Vocational Rehabilitation, AMH, and SPD may offer services to Medicaid eligible clients, which are not reimbursed by or available through the Division of Medical Assistance Programs.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.019, 414.025, 414.065 & 414.705

Medical Assistance Benefits: Out-of-State Services

- (1) Out-of-state Providers must enroll with the Division as described in OARs 407-120-0320 and 410-120-1260, Provider Enrollment. Out-of-state Providers must provide services and bill in compliance with all of these Rules and the OARs for the appropriate type of service(s) provided.
- (2) Payment rates for out-of-state providers are established in the individual provider rules, through contracts or service agreements and in accordance with OAR chapter 943 division 120 and OAR 410-120-1340, Payment.
- (3) For enrolled non-contiguous, out-of-state providers, the Division reimburses for covered services under any of the following conditions:
  - (a) For clients enrolled in a CCO or PHP:
    - (A) The service was authorized by a CCO or PHP and payment to the out-of-State provider is the responsibility of the CCO or PHP;
    - (B) If a client has coverage through a CCO or PHP, the request for non-emergency services must be referred to the CCO or PHP. Payment for these services is the responsibility of the CCO or PHP;
    - (C) The service or item is not available in the State of Oregon or provision of the service or item by an out-of-State provider is cost effective, as determined by the CCO or PHP.
  - (b) For clients not enrolled in a CCO or PHP:
    - (A) The service to a Division client was emergent; or
    - (B) A delay in the provision of services until the client is able to return to Oregon could reasonably be expected to result in prolonged impairment, or in increased risk that treatment will become more complex or hazardous, or in substantially increased risk of the development of chronic illness;
    - (C) The Division authorized payment for the service in advance of the provision of services or was otherwise authorized in accordance with Payment Authorization requirements in the individual provider rules or in the General Rules;
    - (D) The service is being billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage.
- (4) The Division may give prior authorization (PA) for non-emergency out-of-state services provided by a non-contiguous enrolled Provider, under the following conditions:
  - (a) The service is being billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage, or
  - (b) The Division covers the service or item under the specific client's benefit package; and
  - (c) The service or item is not available in the State of Oregon or provision of the service or item by an out-of-state provider is cost effective, as determined by the Division; and
  - (d) The service or item is deemed medically appropriate and is recommended by a referring Oregon physician;
- (5) Laboratory analysis of specimens sent to out-of-state independent or hospital-based Laboratories is a covered service and does not require PA. The Laboratory must meet the same certification requirements as Oregon Laboratories and must bill in accordance with Division rules.

(6) The Division makes no reimbursement for services provided to a Client outside the territorial limits of the United States. For purposes of this provision the "United States" includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

(7) The Division will reimburse, within limits described in these General rules and in individual provider rules, all services provided by enrolled providers to children:

(a) Who the Authority has placed in foster care;

(b) Who the Department has placed in a subsidized adoption outside the State of Oregon; or

(c) Who are in the custody of the Department and traveling with the consent of the Department.

(8) The Division does not require authorization of non-emergency services for the children covered by (7), except as specified in the individual provider rules.

(9) Payment rates for out-of-state providers are established in the individual provider rules, through contracts or service agreements and in accordance with OAR 407-120-0350 and 410-120-1340, Payment.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065 & 414.025

410-120-1210

#### Medical Assistance Benefit Packages and Delivery System

(1) The services clients are eligible to receive are based upon the benefit package for which they are eligible. Not all packages receive the same benefits.

(2) The Division of Medical Assistance Programs (Division) benefit package description, codes, eligibility criteria, coverage, limitations and exclusions are identified in these rules.

(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in each of the Division chapter 410 OARs.

(4) Benefit package descriptions:

(a) Oregon Health Plan (OHP) Plus:

(A) Benefit package identifier: BMH

(B) Eligibility criteria: As defined in federal regulations and in the 1115 OHP waiver demonstration, a client is categorically eligible for medical assistance if he or she is eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria.

(C) Coverage includes:

(i) Services above the funding line on the Health Services Commission's (HSC) Prioritized List of Health Services, (OAR 410-141-0480 through 410-141-0520);

(ii) Ancillary services, (OAR 410-141-0480);

(iii) Chemical dependency services provided through local alcohol and drug treatment providers;

(iv) Mental health services based on the HSC Prioritized List of Health Services, to be provided through Community Mental Health Programs or their subcontractors;

(v) Hospice;

(vi) Post-hospital extended care benefit, up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043), or by the Fully Capitated Health Plan (FCHP) for clients enrolled in an FCHP;

(vii) Cost sharing (e.g., copayments) may apply to some covered services;

(B) Limitations: The following services have limited coverage for non pregnant adults age 21 and older. (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410, division 123);

(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140);

(b) OHP Standard:

(A) Benefit Package identifier code: KIT;

(B) Eligibility criteria: Adults and childless couples who are eligible through the 1115 Medicaid expansion waiver and meet Authority-adopted income and other eligibility criteria; the Department identifies these clients through the program acronym, OHP-OPU;

(C) Coverage includes:

(i) Services above the funding line on the HSC Prioritized List, (OAR 410-141-0480 through 410-141-0520);

(ii) Ancillary services, (OAR 410-141-0480);

(iii) Outpatient chemical dependency services provided through local alcohol and drug treatment providers;

(iv) Outpatient mental health services based on the HSC Prioritized List of Health Services, to be provided through Community Mental Health Programs or their subcontractors;

(v) Hospice;

(vi) Post-hospital extended care benefit, up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043) or by the Fully Capitated Health Plan (FCHP) for clients enrolled in an FCHP.

(B) Limitations: The following services have limited coverage (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410, division 123);

(ii) Selected durable medical equipment and medical supplies (OAR chapter 410, division 122 and 130);

(iii) Selected home enteral/parenteral services (OAR chapter 410, division 148);

(iv) Other limitations as identified in individual Division program administrative rules.

(C) Exclusions: The following services are not covered. Refer to the cited OAR chapters and divisions for details:

(i) Acupuncture services, except when provided for chemical dependency treatment (OAR chapter 410, division 130);

(ii) Chiropractic and osteopathic manipulation services (OAR chapter 410, division 130);

(iii) Hearing aids and related services (i.e., exams for the sole purpose of determining the need for or the type of hearing aid), (OAR chapter 410, division 129);

(iv) Home health services (OAR chapter 410, division 127), except when related to limited EPIV services (OAR chapter 410, division 148);

(v) Non-emergency medical transportation (OAR chapter 410, division 136);

(vi) Occupational therapy services (OAR chapter 410, division 131);

(vii) Physical therapy services (OAR chapter 410, division 131);

(viii) Private duty nursing services (OAR chapter 410, division 132), except when related to limited EPIV services;

(ix) Speech and language therapy services (OAR chapter 410, division 129);

(x) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140);

(xi) Other limitations as identified in individual Division program administrative rules, chapter 410.

(c) OHP with Limited Drug:

(A) Benefit Package identifier: BMM, BMD;

(B) Eligibility criteria: Eligible clients are eligible for Medicare and Medicaid benefits;

(C) Coverage includes:

(i) Services covered by Medicare and OHP Plus as described in section (4) of these rules;

(D) Limitations:

(i) The same as OHP Plus, as described in section (4) of these rules;

(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to:

(I) Benzodiazepines;

(II) Over-the-counter (OTC) drugs;

(III) Barbiturates.

(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug.

(F) Payment for services is limited to the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible;

(G) Cost sharing may apply to some covered services, however, cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package;

(d) Qualified Medicare Beneficiary (QMB)-Only:

(A) Benefit Package identifier code MED:

(B) Eligibility criteria: Eligible clients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage.

(C) Coverage: Is limited to the co-insurance or deductible for the Medicare service. Payment is based on the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible, but no more than the Medicare allowable;

(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare.

(e) Citizen/Alien-Waived Emergency Medical (CAWEM):

(A) Benefit Package identifier CWM:

(B) Eligibility criteria: Eligible clients are non-qualified aliens that are not eligible for other Medicaid programs pursuant to Oregon Administrative Rules (OAR) 461-135-1070;

(C) Coverage is limited to:

(i) Emergency medical services as defined by 42 CFR 440.255. Sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part (the "prudent layperson standard" does not apply to the CAWEM emergency definition);

(ii) Labor and Delivery.

(D) Exclusions: The following services are not covered, even if they are sought as emergency services:

(i) Prenatal or postpartum care;

(ii) Sterilization;

(iii) Family Planning;

(iv) Preventive care;

(v) Organ transplants and transplant-related services;

(vi) Chemotherapy;

(vii) Hospice;

(viii) Home health;

(ix) Private duty nursing;

(x) Dialysis;

(xi) Dental services provided outside of an emergency department hospital setting;

- (xii) Outpatient drugs or over-the-counter products;
- (xiii) Non-emergency medical transportation;
- (xiv) Therapy services;
- (xv) Durable medical equipment and medical supplies;
- (xvi) Rehabilitation services.

(f) CAWEM Plus-CHIP Prenatal coverage for CAWEM (benefit code CWX) - refer to OAR 410-120-0030 for coverage.

(4) Division clients are enrolled for covered health services to be delivered through one of the following means:

(a) Coordinated Care Organization (CCO):

(A) These clients are enrolled in a CCO that provides integrated and coordinated health care;

(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, chemical dependency, mental health services or dental care.

(b) Prepaid Health Plan (PHP):

(A) These clients are enrolled in a PHP for their medical, dental or mental health care;

(B) Most non-emergency services are obtained from the PHP or require a referral from the PHP that is responsible for the provision and reimbursement for the medical, dental or mental health service;

(c) Physician Care Organization (PCO):

(A) These clients are enrolled in a PCO for their medical care;

(B) Inpatient hospital services are not the responsibility of the PCO and are governed by the Fee-for-Service Hospital Services Program rule (OAR 410 Division 125).

(d) Primary Care Managers (PCM):

(A) These clients are enrolled with a PCM for their medical care;

(B) Most non-emergency services provided to clients enrolled with a PCM require referral from the PCM.

(c) Fee-for-service (FFS):

(A) These clients are not enrolled in a CCO, PHP, PCO or assigned to a PCM;

(B) Subject to limitations and restrictions in individual program rules, the client can receive health care from any Division-enrolled provider that accepts FFS clients. The provider will bill the Division directly for any covered service and will receive a fee for the service provided.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.705, 414.706, 414.707, 414.708, 414.710

410-120-1230

## Client Co-payment

(1) Oregon Health Plan (OHP) Plus clients shall be responsible for paying a co-payment for some services. This co-payment shall be paid directly to the provider. A co-payment applies regardless of location of services rendered, i.e., provider's office or client's residence.

(2) The following services are exempt from co-payment:

(a) Emergency medical services, as defined in OAR 410-120-0000;

(b) Family planning services and supplies; and

(c) Prescription drug products for nicotine replacement therapy (NRT);

(3) The following clients are exempt from co-payments:

(a) Pregnant women;

(b) Children under age 19;

(c) Clients receiving services under the home and community based waiver and developmental disability waiver;

(d) Inpatients in a hospital, nursing facility, or Intermediate Care Facility for the Mentally Retarded (ICF/MR); and

(e) American Indian/Alaska Native (AI/AN) clients who are members of a federally recognized Indian tribe or receive services through Indian Health Services (IHS), tribal organization or services provided at an Urban Tribal Health Clinic as provided under Public Law 93-638.

(4) Services to a client cannot be denied solely because of an inability to pay an applicable co-payment. This does not relieve the client of the responsibility to pay applicable co-payment, nor does it prevent the provider from attempting to collect any applicable co-payments from the client; the co-payment is a legal debt, and is due and payable to the provider of service.

(5) A client must pay the co-payment at the time service is provided unless exempted in (2) and (3) above.

(6) OHP Standard co-payments are eliminated for OHP Standard clients effective June 19, 2004. Elimination of co-payments by this rule shall supercede any other General Rules Program rule, 410-120-0000 et seq; any Oregon Health Plan rule, OAR 410-141-0000 et seq; or individual Division program rule(s), that contain or refer to OHP Standard co-payment requirements.

(7) Except for prescription drugs, one co-payment is assessed per provider/ per visit/ per day unless otherwise specified in other Divisions' program administrative rules.

(8) Fee-For-Service co-payment requirements:

(a) The provider must not deduct the co-payment amount from the usual and customary fee submitted on the claim. Except as provided in subsection (2) and (3) of this rule, the Division shall deduct the co-payment from the amount the Division pays to the provider (whether or not provider collects the co-payment from the client);

(b) If the Division's payment is less than the required co-payment, then the co-payment amount to equal to the Division's lesser required payment, unless the client or services is exempt according to exclusions listed in (2), (3) above. The client's co-payment shall constitute payment-in-full;

(c) Unless specified otherwise in individual program rules, and to the extent permitted under 42 CFR 1001.951 – 1001.952, the Division does not require providers to bill or collect a co-payment from the Medicaid client. The provider may choose not to bill or collect a co-payment from a Medicaid client, however, the Division will still deduct the co-payment amount from the Medicaid reimbursement made to the provider;

(d) Prescription drugs ordered through Division of Medical Assistance Program's (Division) Mail Order (a.k.a., Home-Delivery) Pharmacy program are exempt from co-payment.

(9) CCO, PHP or PCO co-payment requirements:

(a) Unless specified otherwise in individual program rules, and to the extent permitted under 42 CFR 447.58 and 447.60, the Division does not require CCOs, PHP or PCOs to bill or collect a co-payment from the Medicaid client. The CCO, PHP or PCO may choose not to bill or collect a co-payment from a Medicaid client, however, the Division will still deduct the co-payment amount from the Medicaid reimbursement made to the CCO, PHP or PCO;

(b) When an CCO, PHP or PCO is operating within the scope of the safe harbor regulation outlined in 42 CFR 1001.952(l), an CCO, PHP or PCO may elect to assess a co-payment on some of the services outlined in table 120-1230-1 but not all. The CCO, PHP or PCO must assure they are working within the provisions of 42 CFR 1003.102(b)(13).

(10) Services that require co-payments are listed in Table 120-1230-1:

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

Stat. Auth.: ORS 413.042

Stat. Implemented: ORS 414.025, 414.065

410-120-1280

## Billing

(1) A provider enrolled with the Division of Medical Assistance Programs (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.

(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:

(a) 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 for any services covered by Medicaid fee-for-service or through contracted health care plans, except any coinsurance, co-payments, and deductibles expressly authorized by Oregon Administrative Rules chapter 410 division 120 or 141:

(A) A Division client for covered benefits; or

(B) A financially responsible relative or representative of that individual.

(b) Exceptions under which an enrolled provider may seek payment from an eligible client or client representative are described below:

- (A) The provider may seek any applicable coinsurance, copayments and deductibles expressly authorized by Division rules 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 OHP eligibility, of OHP managed health plan enrollment, or of other third party insurance coverage, either at the time the service was provided or subsequent to the provision of the service or item, and as a result the provider could not bill the Division, the managed health care plan, or third party payer for any reason, including timeliness of claims, lack of prior authorization, etc. The provider must document attempts to obtain information on eligibility or enrollment;
- (C) The client became eligible for Division benefits retroactively but did not meet other established criteria described in the General Rules Program rules and the appropriate Division Program rules (i.e., retroactive authorization);
- (D) A third party resource made payments directly to the client for services provided;
- (E) The client did not have full Division benefits. Clients receiving a limited Medicaid coverage, such as the Citizen Alien Waived Emergency Medical Program, may be billed for services that are not benefits of those programs. The provider must document pursuant to section (3) of this rule that the client was informed that the service or item would not be covered by the Division;
- (F) The client has requested continuation of benefits during the administrative hearing process and final decision was not in favor of the client. The client will be responsible for any charges since the effective date of the initial notice of denial;
- (G) A client cannot be billed for services or treatment that has been denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.);
- (H) The charge is for a copayment when a client is required to make a copayment as outlined in the Division's General Rules Program rule (410-120-1230) and individual Division Program rules;
- (I) In exceptional circumstances, a client may request continuation of a covered service while asserting the right to privately pay for that service. Under this exceptional circumstance, a client can be billed for a covered service if the client is informed in advance of receiving the specific service of all of the following:
- (i) That the requested service is a covered service and that the provider would be paid in full for the covered service if the claim is submitted to the Division or the client's managed care plan, if the client is a member of a managed care plan; and
  - (ii) The estimated cost of the covered service, including all related charges, the amount that the Division, or the client's managed care plan is required to pay for the service, and that the client cannot be billed for an amount greater than the maximum Division reimbursable rate or managed care plan rate, if the client is a member of a managed care plan; and
  - (iii) That the provider cannot require the client to enter into a voluntary payment agreement for any amount for the covered service; and
  - (iv) That the client knowingly and voluntarily agrees to pay for the covered service, the provider must not submit a claim for payment to the Division or the client's managed care plan; and
  - (v) The provider must be able to document in writing, signed by the client or the client's representative, that the client was provided the information described above; that the client was provided an opportunity to ask questions, obtain additional information and consult with the client's caseworker or client representative; and the client agreed to be responsible for payment by signing

an agreement incorporating all of the information described above. The client must be given a copy of the signed agreement. A provider must not submit a claim for payment for covered services to the Division or to the client's managed care plan that is subject to such agreement.

(3) Non-covered Medicaid services:

(a) A provider may bill a client for services that are not covered by the Division or the managed care plan. However, the client must be informed in advance of receiving the specific service that it is not covered, the estimated cost of the service, and that the client or client's representative is financially responsible for payment for the specific service. providers must be able to document in writing signed by the client or client's representative, that the client was provided this information and the client knowingly and voluntarily agreed to be responsible for payment;

(b) Services which are considered non-covered are listed in the following rules (in rule precedence order):

(A) OAR 410-141-0480, Benefit Package of Covered Services; and

(B) OAR 410-141-0520, Prioritized List of Health Services; and

(C) OAR 410-120-1200, Medical Assistance Benefits: Excluded services and limitations; and

(D) Applicable Division Program rules;

(c) 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.

(4) All claims must be billed on the appropriate form as described in the individual Division Program rules or submitted electronically in a manner authorized by the Authority's Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et. seq.

(5) 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.

(6) All billings must be for services provided within the provider's licensure or certification.

(7) 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.

(8) A claim must not be submitted prior to delivery of service. A claim must not be submitted prior to dispensing, shipment or mailing of the item unless specified otherwise in the Division's individual Program rules.

(9) 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. Also, see valid claim in the Definitions section of these rules.

(10) The HIPAA Codes rules, 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 162.100, and it includes the codes and the descriptors of the codes. These 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.

(a) The Division will adhere to the national Code Set requirements in 45 CFR 162.1000 — 162.1011, regardless of whether a request is made verbally, or a claim is submitted on paper or electronically;

(b) 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 and the provider, and the Division-listed code may be used for the limited purpose of describing the Division's intent in identifying the applicable national code;

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

(d) 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) to be effective January 1, 2007. This code adoption should not be construed as Authority coverage, or a covered service.

(11) 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) When billing using ICD-9-CM codes, 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.

(12) 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. 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:

(a) 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;

(b) 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.

(13) No provider or its contracted agency (including billing providers) shall submit or cause to be submitted to the Division:

(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.

(14) 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.

(15) 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.

(16) Third party resources (TPR):

(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, but are not limited to:

(A) Determining the existence of insurance or other resource by asking the recipient;

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

(C) Verifying the client's insurance coverage through 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 (16) (d) (A through E), when third party coverage is known to the provider, as indicated through AVR, Secure provider web portal or any other means available, prior to billing the Division the provider must:

(A) Bill the TPR; 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 TPR prior to billing the Division, except under the following circumstances:

(A) The covered health service is provided by an Intermediate Care Facility Services for the Mentally Retarded (ICF/MR);

(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 Division within 12 months of the date of service. If the provider

bills Division the provider must accept payment made by the Division as payment in full.

(F) 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:

(i) In the circumstances outlined in (16)(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;

(ii) 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.

(e) 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;

(f) 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) Except as described in (15), any provider who accepts third party payment for furnishing a service or item to a Division client shall:

(i) Submit an Individual Adjustment Request after submitting a claim to the Division following instructions in the individual provider rules and supplemental billing information, indicating the amount of the third party payment; 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. When the provider chooses to directly repay the amount of the third party payment to the Division, the provider must indicate the reason the payment is being made and must submit with the check:

(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.

(g) 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 (15) of this rule;

(h) 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.

(i) 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.

(17) 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 (18) 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.

(18) Exceptions:

(a) Indian Health Services or Tribal Health Facilities. Pursuant to 42 CFR 35.61 subpart G and the Memorandum of Agreement in OAR 310-146-0000, Indian Health Services facilities and tribal facilities operating under a section 638 agreement are payers of last resort, and are not considered an alternate resource or TPR;

(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 TPR.

(19) Table 120-1280- TPR codes.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065 & 414.085

Hist.: PWC 683, f. 7-19-74, ef. 8-11-74

## Non-Participating Provider

(1) For purposes of this rule, a provider enrolled with the Division of Medical Assistance Programs (Division) that does not have a contract with a Division-contracted Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) is referred to as a non-participating provider.

(2) For covered services that are subject to reimbursement from the CCO or PHP, a non-participating provider, other than a hospital governed by (3) below, must accept from the Division-contracted CCO or PHP, as payment in full, the amount that the provider would be paid from the Division if the client was fee-for-service (FFS).

(3) For covered services provided on and after October 1, 2011, the Division-contracted CCO or Fully Capitated Health Plan (FCHP) that does not have a contract with a hospital, is required to reimburse, and hospitals are required to accept as payment in full, the following reimbursement:

(a) Non-participating Type A and Type B hospital: The CCO or FCHP shall reimburse a non-participating Type A and Type B hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the global payments to the CCO for the contract period or for the capitation rates paid to the FCHP for the contract period.(ORS 414.727);

(b) All other non-participating hospitals (not designated as a rural access or Type A and Type B hospital): As specified in ORS 414.743, the CCO or FCHP shall reimburse inpatient and outpatient services using a Medicare payment methodology at a specified percentage point less than the percentage of Medicare costs used by the Oregon Health Authority (Authority) when calculating the base hospital capitation payment to the CCO or FCHP's, excluding any supplemental payments.

(i) Effective for services on or after October 1, 2011, for a hospital providing 10 percent or more of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 64 percent;

(ii) Effective for services on or after October 1, 2011, for a hospital providing less than 10 percent of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 66 percent.

(4) A non-participating hospital must notify the CCO or FCHP within 2 business days of an CCO or FCHP patient admission when the CCO or FCHP is the primary payer. Failure to notify does not, in and of itself, result in denial for payment. The CCO or FCHP is required to review the hospital claim for:

(a) Medical appropriateness;

(b) Compliance with emergency admission or prior authorization policies;

(c) Member's benefit package;

(d) The CCO or FCHP contract and the Division's administrative rules.

(5) After notification from the non-participating hospital, the CCO or FCHP may:

(a) Arrange for a transfer to a contracted facility, if the patient is medically stable and the CCO or FCHP has secured another facility to accept the patient;

(b) Perform concurrent review; and/or

(c) Perform case management activities.

(6) In the event of a disagreement between the CCO or FCHP and hospital, the provider may appeal the decision by asking for an administrative review as specified in OAR 410-120-1580.

Stat. Auth.: ORS 409.040, 409.050& 414.065

Stats. Implemented: ORS 414.025, 414.065, 414.705 & 414.743

410-120-1320

### Payment Authorization

(1) Some services or items covered by the Division of Medical Assistance Programs (Division) require authorization before the service can be provided. See the appropriate Division rules for information on services requiring authorization and the process to be followed to obtain authorization.

(2) Documentation submitted when requesting authorization must support the medical justification for the service. A complete request is one that contains all necessary documentation and meets any other requirements as described in the appropriate Division rules.

(3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

(4) The Division will not make payment for authorized services under the following circumstances:

(a) The client was not eligible at the time services were provided. The provider is responsible for checking the client's eligibility each time services are provided;

(b) The provider cannot produce appropriate documentation to support medical appropriateness, or the appropriate documentation was not submitted to the authorizing agency;

(c) The service has not been adequately documented (see 410-120-1360, Requirements for Financial, Clinical and Other Records); that is, the documentation in the provider's files is not adequate to determine the type, medical appropriateness, or quantity of services provided and required documentation is not in the provider's files;

(d) The services billed or provided are not consistent with the information submitted when authorization was requested or the services provided are determined retrospectively not to be medically appropriate;

(e) The services billed are not consistent with those provided;

(f) The services were not provided within the timeframe specified on the authorization of payment document;

(g) The services were not authorized or provided in compliance with the rules in these General Rules and in the appropriate provider rules.

(5) Retroactive authorizations:

(a) Authorization for payment may be given for a past date of service if:

(A) The client was made retroactively eligible or was retroactively disenrolled from a CCO or PHP on the date of service;

- (B) The services provided meet all other criteria and Oregon Administrative Rules, and;
- (C) The request for authorization is received within 90 days of the date of service;
- (c) Any requests for authorization after 90 days from date of service require documentation from the Provider that authorization could not have been obtained within 90 days of the date of service.
- (7) Payment authorization is valid for the time period specified on the authorization notice, but not to exceed 12 months, unless the Client's benefit package no longer covers the service, in which case the authorization will terminate on the date coverage ends.
- (8) When clients have other health care coverage (third-party resources, or TPR), the Division only requires payment authorization for the services that TPR does not cover. Examples include::
  - (a) When Medicare is the primary payer for a service, no payment authorization from the Division is required, unless specified in the appropriate Division program rules;
  - (b) When other TPR is primary, such as Blue Cross, CHAMPUS, etc., the Division requires payment authorization when the other insurer or resource does not cover the service or reimburses less than the Division rate.

Stat. Auth.: ORS 409.050, 409.010, 409.110 & 414.065

Stats. Implemented: ORS 414.065

#### 410-120-1340 Payment

- (1) The Division of Medical Assistance Programs (Division) shall make payment only to the enrolled provider (see OAR 410-120-1260) who actually performs the service or to the provider's enrolled billing provider for covered services rendered to eligible clients. Any contracted billing agent or billing service submitting claims on behalf of a provider but not receiving payment in the name of or on behalf of the provider does not meet the requirements for billing provider enrollment. If billing agents and billing services intend to submit electronic transactions they must register and comply with the Oregon Health Authority (Authority) Electronic Data Interchange (EDI) rules, OAR 407-120-0100 through 407-120-0200. Division reimbursement for services may be subject to review prior to reimbursement.
- (2) The Division (Division of Medical Assistance Programs or another Division within the Authority) that is administering the program under which the billed services or items are provided sets fee-for-service (FFS) payment rates.
- (3) 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;
- (4) Amount billed may not exceed the provider's "usual charge" (see definitions);
- (5) The Division's maximum allowable rate setting process uses the following methodology. The rates are updated periodically and posted on the Authority web site at [http://www.oregon.gov/OHA/healthplan/data\\_pubs/feeschedule/main.shtml](http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml):

- (a) Relative Value Unit (RVU) weight-based rates: For all CPT/HCPCS codes assigned an RVU weight, the Division shall use the 2010 Transitional Total RVU weights published in the Federal Register, Vol. 74, November 25, 2009 with technical corrections published Dec. 10, 2009, to be effective for dates of services on or after January 1, 2011.
- (A) For professional services not typically performed in a facility, the Non-Facility Total RVU weight shall be adopted;
- (B) For professional services typically performed in a facility the Transitional Facility Total RVU weight shall be adopted;
- (b) The Division applies the following conversion factors:
- (A) \$40.79 for labor and delivery codes (59400-59622);
- (B) \$27.82 for primary care providers and services. A current list of primary care CPT, HCPCS and provider specialty codes is available at [http://www.oregon.gov/OHA/healthplan/data\\_pubs/feeschedule/main.shtml](http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml)
- (C) \$25.48 for all remaining RVU weight based CPT/HCPCS codes ;
- (D) \$26.81 for vision codes (92340-92342 and 92352-92353) regardless of the RVU.
- (6) Other non RVU based rates:
- (a) Surgical assist reimburses at 20% of the surgical rate;
- (b) \$20.78 is the base rate for anesthesia service codes 00100-01996. The rate is based on per unit of service;
- (c) Clinical lab codes are priced at 70% of the Medicare clinical lab fee schedule;
- (d) All approved Ambulatory Surgical Center (ASC) procedures are reimbursed at 80% of the Medicare fee schedule;
- (e) Physician administered drugs, billed under a HCPCS code, are based on Medicare's Average Sale Price (ASP). When no ASP rate is listed the rate shall be based upon the Wholesale Acquisition Price (WAC) plus 6.25%. If no WAC is available, then the rate shall be reimbursed at Acquisition Cost. Pricing information for WAC is provided by First Data Bank. These rates may change periodically based on drug costs;
- (f) All procedures used for vision materials and supplies are based on contracted rates that include acquisition cost plus shipping and handling.
- (g) Individual provider rules may specify reimbursement rates for particular services or items.
- (7) The Division reimburses inpatient hospital service under the DRG methodology, unless specified otherwise in the Division's Hospital Services Program administrative rules (chapter 410, division 125). Reimbursement for services, including claims paid at DRG rates, shall not exceed any upper limits established by federal regulation.
- (8) The Division reimburses all out-of-state hospital services at Oregon DRG or FFS rates as published in the Hospital Services Program rules (OAR chapter 410, division 125) unless the hospital has a contract or service agreement with the Division to provide highly specialized services.
- (9) Payment rates for in-home services provided through Department of Human Services (Department) Aged and Physically Disabled Division (APD) will not be greater than the current Division rate for nursing facility payment.

(10) The Division sets payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities, psychiatric and rehabilitative care facilities at a rate that is:

(a) Consistent with similar services provided in the State of Oregon; and

(b) The lesser of the rate paid to the most similar facility licensed in the State of Oregon or the rate paid by the Medical Assistance Programs in that state for that service; or

(c) The rate established by APD for out-of-state nursing facilities.

(11) The Division shall not make payment on claims that have been assigned, sold, or otherwise transferred or when the billing provider, billing agent or billing service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a provider for accounts receivable.

(12) The Division shall not make a separate payment or copayment to a nursing facility or other provider for services included in the nursing facility's all-inclusive rate. The following services are not included in the all-inclusive rate (OAR 411-070-0085) and may be separately reimbursed:

(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services Program administrative rules (chapter 410, division 121) and Home Enteral/Parenteral Nutrition and IV Services Program administrative rules, (chapter 410, division 148);

(b) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the appropriate program administrative rules, (chapter 410, division 129 and 131);

(c) Continuous oxygen which exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Program administrative rules, (chapter 410, division 122);

(d) Influenza immunization serum as described in the Pharmaceutical Services Program administrative rules, (chapter 410, division 121);

(e) Podiatry services provided under the rules in the Medical-Surgical Services Program administrative rules, (chapter 410, division 130);

(f) Medical services provided by a physician or other provider of medical services, such as radiology and laboratory, as outlined in the Medical-Surgical Services Program rules, (chapter 410, division 130);

(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).

(13) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSA's). A separate payment will not be made for services included in the core package of services as outlined in OAR chapter 410, division 142.

(14) Payment for Division clients with Medicare and full Medicaid:

(a) The Division limits payment to the Medicaid allowed amount, less the Medicare payment, up to the Medicare co-insurance and deductible, whichever is less. The Division's payment cannot exceed the co-insurance and deductible amounts due;

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

(15) For clients with third-party resources (TPR), the Division pays the Division allowed rate less the TPR payment but not to exceed the billed amount.

(16) The Division payments, including contracted PHP or CCO payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For the Division, such payment in full includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding Division allowable payment; and

(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain payment authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual provider rules.

(17) Payment by the Division does not restrict or limit the Authority or any state or federal oversight entity's right to review or audit a claim before or after the payment. Claim payment may be denied or subject to recovery if medical review, audit or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment.

Stat. Auth.: ORS 413.042

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

410-120-1560

#### Provider Appeals

(1) For purposes of Division of Medical Assistance Programs (Division) provider appeal rules in chapter 410, division 120 the following terms and definitions are used:

(a) "Provider" means a person or entity enrolled with the Division, or under contract with the Division that is subject to the Division rules, that has requested an appeal in relation to health care, items, drugs or services provided or requested to be provided to a client on a fee-for-service basis or under contract with the Division where that contract expressly incorporates these rules;

(b) "Provider Applicant" means a person or entity that has submitted an application to become an enrolled provider with the Division but the application has not been approved;

(c) "Prepaid Health Plan" has the meaning in OAR 410-141-0000, except to the extent that Mental Health Organizations (MHO) have separate procedures applicable to provider grievances and appeals;

(d) "Prepaid Health Plan provider" means a person or entity enrolled with the Division but that provided health care services, supplies or items to a client enrolled with a PHP, including both participating providers and non-participating providers as those terms are defined in OAR 410-141-0000, except that services provided to a client enrolled with an MHO shall be governed by the provider grievance and appeal procedures administered by the Office of Mental Health and Addiction Services;

(e) The "Provider Appeal Rules" refers to the rules in OAR 410-120-1560 to 410-120-1700, describing the availability of appeal procedures and the procedures applicable to each appeal procedure;

- (f) “Non-participating provider” has the meaning in OAR 410-141-0000;
  - (g) Coordinated Care Organization (CCO) has the meaning in OAR 410-141-0000,
- (2) A Division of Medical Assistance Programs (Division) enrolled provider may appeal a Division decision in which the provider is directly adversely affected such as the following:
- (a) A denial or limitation of payment allowed for services or items provided;
  - (b) A denial related to a NCCI edit;
  - (c) A denial of provider’s application for new or continued participation in the Medical Assistance Program; or
  - (d) Sanctions imposed, or intended to be imposed, by the Medical Assistance program on a provider or provider entity; and
  - (e) Division overpayment determinations made under OAR 410-120-1397.
- (3) Client appeals of actions must be handled in accordance with OAR 140-120-1860 and 410-120-1865.
- (4) A provider appeal is initiated by filing a timely request in writing for review with the Division.
- (a) A provider appeal request is not required to follow a specific format as long as it provides a clear written expression from a provider or provider applicant expressing disagreement with a Division decision or from a CCO or PHP provider expressing disagreement with a decision by a CCO or PHP.
  - (b) The request should identify the decision made by the Division or a CCO or PHP that is being appealed and the reason the provider disagrees with that decision.
  - (c) A provider appeal request is timely if it is received by the Division within 180 calendar days of the date of the Division’s decision or 30 calendar days of the date of the CCO or PHP decision on the provider’s appeal to the CCO or PHP.
- (5) Types and methods for provider appeals are listed below.
- (a) A Division of Medical Assistance Programs (Division) denial of or limitation of payment allowed, Division claim decision including prior authorization decision, or Division overpayment determination for services or items provided to a client must be appealed as claim re-determinations under OAR 410-120-1570.
  - (b) A notice of sanctions imposed, or intended to be imposed, the effect of the notice of sanction is, or will be, to deny suspend or revoke a provider number necessary to participate in the medical assistance on a provider, or provider applicant is entitled to appeal under OAR 410-120-1600. A provider that is entitled to appeal a notice of sanction as a contested case may request administrative review instead of contested case hearing if the provider submits a written request for administrative review of the notice of sanction and agrees in writing to waive the right to a contested case hearing and the Division agrees to review the appeal of the notice of sanction as an administrative review.
  - (c) All provider appeals of Division decisions not described in paragraphs (4)(a) or (b) are handled as administrative reviews in accordance with OAR 410-120-1580, unless Division issues an order granting a contested case hearing.
- (6) Decisions that adversely affect a provider may be made by different program areas within the Authority.

(a) Decisions issued by the Office of Payment Accuracy and Recovery (OPAR) or the Authority information security office shall be appealed in accordance with the process described in the notice,

(b) Other program areas within the Authority that have responsibility for administering medical assistance funding, such as nursing home care or community mental health and developmental disabilities program services, may make decisions that adversely affect a provider. Those providers are subject to the provider grievance or appeal processes applicable to those payment or program areas.

(c) Some decisions that adversely affect a provider are issued on behalf of the Division by Authority contractors such as the Division pharmacy benefits manager, by entities performing statutory functions related to the medical assistance programs such as the Drug Use Review Board, or by other entities in the conduct of program integrity activities applicable to the administration of the medical assistance programs. For these decisions made on behalf of the division in which the Division has legal authority to make the final decision in the matter, a provider may appeal such a decision to the Division as an administrative review and the Division may accept such review.

(d) This rule does not apply to contract administration issues that may arise solely between the Division and a CCO or PHP. Such issues shall be governed by the terms of the applicable contract.

(e) The Division provides limited provider appeals for CCO or PHP providers or non-participating providers concerning a decision by a CCO or PHP. In general, the relationship between a CCO or PHP and their providers is a contract matter between them. Client appeals are handled under the client appeal rules, not provider appeal rules.

(i) The CCO or PHP provider seeking a provider appeal must have a current valid provider enrollment agreement with the Division and, unless the provider is a non-participating provider, must also have a contract with the CCO or PHP as a CCO or PHP provider; and

(ii) The CCO or PHP provider or non-participating provider must have exhausted the applicable appeal procedure established by the CCO or PHP and the request for provider appeal must include a copy of the written decision(s) of the CCO or PHP that is being appealed from and a copy of any CCO or PHP policy being applied in the appeal; and

(iii) The CCO or PHP provider appeal or non-participating provider appeal from a CCO or PHP decision is limited to issues related to the scope of coverage and authorization of services under the Oregon Health Plan, including whether services are included as covered on the Prioritized List, guidelines, and in the OHP Benefit package. The Division provider appeal process does not include CCO or PHP payment or claims reimbursement amount issues, except in relation to non-participating provider matters governed by Division rule.

(iv) A timely provider appeal must be made within 30 calendar days from the date of the CCO or PHP's decision and include evidence that the PHP was sent a copy of the provider appeal. In every provider appeal involving a CCO or PHP decision, the CCO or PHP will be treated as a participant in the appeal.

(7) In the event a request for provider appeal is not timely, the Division will determine whether the failure to file the request was caused by circumstances beyond the control of the provider, provider applicant or CCO or PHP provider. In determining whether to accept a late request for review, the Division requires the request to be supported by a written statement that explains why the request for review is late. The Division may conduct such further inquiry as the Division deems appropriate. In determining timeliness of filing a request for review, the amount of time that the Division determines accounts for circumstances beyond the control of the provider is not counted. The Division may refer an untimely request to the Office of Administrative Hearings for a hearing on the question of timeliness.

(8) The burden of presenting evidence to support a provider appeal is on the provider, provider applicant CCO or PHP provider.

(a) Consistent with OAR 410-120-1360, payment on a claim will only be made for services that are adequately documented and billed in accordance with OAR 410-120-1280 and all applicable administrative rules related to covered services for the client's benefit package and establishing the conditions under which services, supplies or items are covered, such as the Prioritized List, medical appropriateness and other applicable standards.

(b) Eligibility for enrollment and for continued enrollment is based on compliance with applicable rules, the information submitted or required to be submitted with the application for enrollment and the enrollment agreement, and the documentation required to be produced or maintained in accordance with OAR 410-120-1360.

(9) Provider appeal proceedings, if any, will be held in Salem, unless otherwise stipulated to by all parties and agreed to by the Division.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 409.010

410-120-1570

#### Claim Re-Determinations

(1) If a provider disagrees with an initial claim determination made by the Division of Medical Assistance Program (Division), the provider may request a review for re-determination of the denied claim payment.

(2) This rule does not apply to determinations that:

(a) Result in a "Notice of Action" that must be provided to the OHP client. If the decision under review requires any notice to the OHP client under applicable rules (OAR 410-120-1860, 410-414-0263), the procedures for notices and hearings must be followed; or

(b) Are made by a CCO or PHP regarding services to a CCO or PHP member. The provider must contact the CCO or PHP in accordance with 410-120-1560.

(3) How to request a redetermination review:

(a) To request a review, the provider must submit a written request to the Division Provider Services Unit within 180 days of the original claim adjudication date.

(b) The written request must include all information needed to adjudicate the claim or support changing the original claim determination, including but not limited to:

(A) A detailed letter of explanation identifying the specific re-determination denial issue and/or alleged error;

(B) All relevant medical records and evidence-based practice data to support the position being asserted on review;

(C) The specific service, supply or item being denied, including all relevant codes;

(D) Detailed justification for the re-determination of the denied service; and

(E) A copy of the original claim and a copy of the original denial notice or remittance advice that describes the basis for the claim denial under re-determination;

(F) Any information and/or medical documentation pertinent to support the request and to obtain a resolution of the re-determination review dispute.

(4) A provider requesting a re-determination review must demonstrate one or more of the following reasons that would allow coverage in the particular case:

(a) A below-the-line condition/treatment pair is justified under the co-morbid rule OAR 410-141-0480(8);

(b) A treatment that is part of a covered complex procedure and/or related to an existing funded condition;

(c) A service not listed on the HSC Prioritized List that may be covered under OAR 410-141-0480(10);

(d) A service that satisfies the Citizen/Alien-Waived Emergency Medical (CAWEM) emergency service criteria;

(e) Medical documentation of applicable evidence-based practice literature that is consistent with the condition or service under review;

(f) A service that satisfies the prudent layperson definition of emergency medical condition;

(g) A service intended to prolong survival or palliate symptoms, due to expected length of life consistent with the HSC Statement of Intent for Comfort/Palliative Care;

(h) A service that should be covered where denial was due to technical errors and omissions with the Oregon Health Services Commission's (HSC) Prioritized List of approved Health Services

(i) Misapplication of a fee schedule;

(j) A denied duplicate claim that the provider believes were incorrectly identified as a duplicate;

(k) Incorrect data items, such as provider number, use of a modifier or date of service, unit changes or incorrect charges;

(l) Errors with the Medicaid Management Information System (MMIS), such as a code is missing in MMIS that the Oregon Health Services Commission (HSC) has placed on the Prioritized List of Health Services;

(m) Services provided without the required prior-authorization, except for those authorizations subject to provision outlined in OAR 410-120-1280(2)(a)(C);

(n) A covered diagnostic service.

(5) The Division will review all re-determination requests as follows:

(a) The review is based on the Division review of supplied documentation and applicable law(s);

(b) The Division may request additional information from the provider that it finds relevant to the request under review;

(c) The Division does not provide a face-to-face meeting with providers as part of the re-determination review process.

(d) The Division will notify a provider requesting review that the re-determination request has been denied if:

(A) The provider did not submit a timely request;

(B) The required information is not provided at the same time the request is submitted; and/or

(C) The provider fails to submit any additional requested information within 14 business days of request.

(7) The Division's final decision under this rule is the final decision on appeal. Under ORS 183.484, this decision is an order in other than a contested case. ORS 183.484 and the procedures in OAR 137-004-0080 to 137-004-0092 apply to the Division's final decision under this rule.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-120-1580

### Provider Appeals — Administrative Review

(1) An administrative review is a provider appeal process that allows an opportunity for the Administrator of the Division of Medical Assistance Programs (Division) or designee to review a Division decision affecting the provider, provider applicant, Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) provider, where administrative review is appropriate and consistent with these provider appeal rules OAR 410-120-1560.

(2) Administrative review is an appeal process under OAR 410-120-1560 that addresses primarily legal or policy issues that may arise in the context of a Division decision that adversely affects the Provider and that is not otherwise reviewed as a claim re-determination, a contested case, or client appeal.

(a) If the Division finds that the appeal should be handled as a different form of provider appeal or as a client appeal, the Administrator or designee will notify the provider of this determination.

(b) Within the time limits established by the Division in the administrative review, the provider, provider applicant, CCO or PHP provider must provide Division (and CCO or PHP, if applicable) with a copy of all relevant records, the Division, CCO or PHP decisions, and other materials relevant to the appeal.

(3) If the Administrator or designee decides that a meeting between the provider, provider applicant, CCO or PHP Provider (and CCO or PHP, if applicable) and the Division staff will assist the review, the Administrator or designee will:

(a) Notify the provider requesting the review of the date, time, and place the meeting is scheduled;

(b) Notify the CCO or PHP (when client is enrolled in a CCO or PHP) of the date, time, and place the meeting is scheduled. The CCO or PHP is not required to participate, but is invited to participate in the process.

(4) The review meeting will be conducted in the following manner:

(a) It will be conducted by the Division Administrator, or designee;

(b) No minutes or transcript of the review will be made;

- (c) The provider requesting the review does not have to be represented by counsel during an administrative review meeting and will be given ample opportunity to present relevant information;
- (d) The Division staff will not be available for cross-examination, but the Division staff may attend and participate in the review meeting;
- (e) Failure to appear without good cause constitutes acceptance of the Division's determination;
- (f) The Administrator may combine similar administrative review proceedings, including the meeting, if the Administrator determines that joint proceedings may facilitate the review;
- (g) The Division Administrator or designee may request the provider, provider Applicant, CCO or PHP Provider making the appeal to submit, in writing, new information that has been presented orally. In such an instance, a specific date for receiving such information will be established.
- (5) The results of the administrative review will be sent to the participants, involved in the review, and to the CCO or PHP when review involved a CCO or PHP provider, in writing, within 30 calendar days of the conclusion of the administrative review proceeding, or such time as may be agreed to by the participants and the Division.
- (6) The department's final decision on administrative review is the final decision on appeal and binding on the parties. Under ORS 183.484, this decision is an order in other than a contested case. ORS 183.484 and the procedures in OAR 137-004-0080 to 137-004-0092 apply to the department's final decision on administrative review.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-120-1600

#### Provider Appeals — Contested Case Hearings

- (1) A contested case procedure is a hearing that is conducted by the Office of Administrative Hearings where a contested case is appropriate and consistent with the provider appeal rules OAR 410-120-1560. If the request for contested case hearing was timely filed but should have been filed as a claim redetermination or administrative review, or client appeal, Division will refer the request to the proper appeal procedure and notify the Provider, provider applicant, CCO or PHP provider.
- (2) Contested case hearings are conducted in accordance with the Attorney General's model rules at OAR 137-003-0501 to 137-003-0700.
- (3) The party to a provider contested case hearing is the provider, provider applicant, CCO or PHP provider who requested the appeal. In the event that Division determines that a CCO or PHP provider is entitled to a Contested Case Hearing under OAR 410-120-1560, the CCO or PHP Provider and the CCO or PHP are parties to the hearing. A provider, CCO or PHP provider, CCO or PHP that is a corporation may be represented by any of the persons identified in ORS 410.190.
- (4) Informal conference: Division may notify the provider(s) provider applicant, CCO or PHP provider (and CCO or PHP, if applicable) of the time and place of an informal conference, without the presence of the Administrative Law Judge (ALJ). The purposes of this informal conference are:
  - (a) To provide an opportunity to settle the matter;
  - (b) To make sure the parties and the Authority understand the specific reason for the action of the hearing request;

(c) To give the parties and the Authority an opportunity to review the information which is the basis for action;

(d) To give the parties and the Authority the chance to correct any misunderstanding of the facts; and

(e) The provider, provider applicant, CCO or PHP provider (or CCO, PHP, if applicable) may, at any time prior to the hearing date, request an additional informal conference with the Division and Authority representative(s), which may be granted if the Division finds at its sole discretion, the additional informal conference will facilitate the Contested Case Hearing process or resolution of disputed issues.

(5) Contested Case Hearing: The Administrative Law Judge (ALJ) will conduct the contested case hearing using the Attorney General's Model Rules at OAR 137-003-0501 to 137-003-0700.

(a) The burden of presenting evidence to support a provider appeal is on the provider, provider applicant, CCO or PHP provider that requested the appeal. Consistent with OAR 410-120-1360, payment on a claim will only be made for services that are adequately documented and billed in accordance with OAR 410-120-1280 and all applicable administrative rules related to covered services for the Client's benefit package and establishing the conditions under which services, supplies or items are covered, such as the Prioritized List, medical appropriateness and other applicable standards.

(b) Subject to Division approval under OAR 137-003-0525, the ALJ will determine the location of the Contested Case Hearings.

(6) Proposed and Final Orders: The ALJ is authorized to 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 by the ALJ.

(a) If the ALJ issues a proposed order, and the proposed order is adverse to a party, the party may file written exceptions to the proposed order to be considered by the Division, or the ALJ when the ALJ is authorized to issue the final order. The exceptions must be in writing and received by the Division, or the ALJ when the ALJ is authorized to issue the final order, not later than 10 calendar days after the date of the proposed order is issued by the ALJ. No additional evidence may be submitted without prior approval of Division.

(b) The proposed order issued by the ALJ will become a final order if no exceptions are filed within the time specified in subsection (a) of this rule, unless the Division notifies the parties and the ALJ that Division will issue the final order. After receiving the exceptions or argument, 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, Division may issue an amended proposed order.

(c) Procedures applicable to default orders for withdrawal of a hearing request, failure to timely request a hearing, failure to appear at a hearing, or other default, are governed by the Attorney General's Model Rules, OAR 137-003-0670 – 137-003-0672.

(d) The final order is effective immediately upon being signed or as otherwise provided in the order.

(7) All Contested Case Hearing decisions are subject to the procedures established in OAR 137-003-675 to 137-003-0700 and to judicial review under ORS 183.482 in the Court of Appeals.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

## 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 OAR 410-141-0360 or 0260. 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 Authority's Administrative Hearing request form (DMAP 443) 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 failure to timely file the hearing request was caused by circumstances beyond the control of the client and enter an order accordingly. 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. In determining timeliness of filing a hearing request, the amount of time that the Division determines accounts for circumstances beyond the control of the client is not counted. The Division may refer an untimely request to the Office of Administrative Hearings for a hearing on the question of timeliness;

(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;

(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.

(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, and 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 on a showing that the party was unable to attend the hearing and unable to request a postponement for reasons beyond his or her control.

(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

#### 410-120-1880 Contracted Services

(1) Except as otherwise provided in OAR 410-120-1260 et seq. applicable to provider enrollment or OAR 410-141-0000, 410-141-3010 et seq. governing CCO or PHPs, insurance and service contracts as provided for under ORS 414.115, 414.125, 414.135 and 414.145 may be implemented for covered medical assistance services in any program area(s) of the Oregon Health Authority (Authority) in order to achieve one or more of the following purposes:

(a) To implement and maintain CCO or PHP services;

(b) To ensure access to appropriate Medical Services that would not otherwise be available;

(c) To more fully specify the scope, quantity, or quality of the services to be provided or to specify requirements of the provider or to specify requirements of the Authority in relation to the provider;

(d) To obtain services more cost effectively, (e.g., to reduce the costs of program administration or to obtain comparable services at less cost than the fee-for-service rate).

(2) Contracts, interagency agreements, or intergovernmental agreements under OAR 410-120-1880, subsection (1) funded with federal funds will be subject to applicable federal procurement and contracting requirements, and this rule will be interpreted and applied to satisfy such requirements. To the extent required by the federal funding agency, the Authority will seek prior federal approval of solicitations and/or contracts when the Authority plans to acquire or enhance services or equipment that will be paid in whole or on part with federal funds.

(3) The Authority is exempt from the Public Contracting Code for purposes of source selection pursuant to ORS 279A.025(2). The Authority will use the following source selection procedures when entering into contracts under OAR 410-120-1880, subsection (1). Interagency agreements and intergovernmental agreements are not subject to competitive solicitation as the basis of source selection, and may be selected in accordance with ORS 190.003 to 190.130 and other applicable law or authority. Competition must be used in obtaining contract services to the maximum extent practical, except as otherwise provided in subsection (4):

(a) Small procurement procedure may be used for the procurement of supplies and services less than or equal to \$5,000. The Authority may use any method reasonably appropriate to the nature of the supply or service and the business needs of the Authority to identify potential contractors;

(b) Informal solicitation procedure may be used for the procurement of services if the estimated cost or contract price is \$150,000 or less. Proposals will be solicited from at least three sources, except as otherwise provided in these rules;

(c) Formal solicitation procedure will be used for the procurement of services when the estimated cost or contract price is more than \$150,000. Proposals must be solicited as outlined in these rules.

(4) Selection by negotiation may be used in lieu of a competitive procurement under subsection (3) of this rule for the procurement of goods or services if:

(a) The good or service is available only from a single source or the sole source has special skills that are only available based upon his or her expertise or situation. If the Authority Director, or designee, determines that only a single contractor is available or practical for purposes of this rule, the Director or designee may approve selection by negotiation. A memorandum signed by the Director or designee setting forth the reasons for using a sole source contract must be placed in the contract file;

(b) Public need, significant risk of interruption of services, or emergency advises against a delay incident to competitive solicitation. If the Authority Director, or designee, determines that an emergency exists for purposes of this rule, the Director or designee may approve selection by negotiation. A memorandum signed by the Director or designee setting forth the nature of the emergency must be placed in the file;

(c) Compliance with federal requirements necessitated proceeding without competitive solicitation. Documentation of the applicable federal requirements must be placed in the contract file;

(d) Other authority including but not limited to statutory authority in ORS 414.115, 414.125, 414.135, and 414.145, or such other authority, exemptions and delegations of authority that may be applicable to the source selection for the procurement: Documentation of the authority must be placed in the contract file.

(5) A Request for Proposal (RFP) or similar solicitation mechanism must be prepared for contracts for which the Formal Solicitation Procedure will be used. The solicitation document should include at a minimum the following elements, when applicable:

- (a) Statement of required work, including a clear description of the services to be provided, standards by which performance of the services will be measured and/or conditions affecting the delivery of services;
  - (b) Minimum standards and qualifications which contractors must meet to be eligible to provide the services;
  - (c) Information which the prospective contractors must submit in their proposals to support their capability, such as references and experience providing the same or similar services (when, where, for whom, type of service, etc.);
  - (d) Funding information and budget requirements;
  - (e) Information about ownership interests in software or hardware designed, acquired, developed or installed with federal funds, in compliance with federal requirements for ownership, management and disposition;
  - (f) The form and organization of proposals, when and where proposals are to be submitted, whether late proposals may be considered, and when an award of a contract is expected;
  - (g) The method and criteria to be used in evaluating proposals and the weighting assigned to each criterion;
  - (h) Provisions stating how and when the solicitation document must be contested, and how and when the final award must be contested;
  - (i) Notice that all costs incurred in the preparation of a proposal will be the responsibility of the proposer and will not be reimbursed by the Authority; and
  - (j) Contract provisions, subject to subsection (8) of this rule.
- (6) Proposals must be evaluated in a manner consistent with the evaluation criteria in the solicitation document. A written document stating why the selection was made will be placed in the contract file.
- (7) Unless exempt under ORS 291.045 to 291.049 or rules adopted there under, the Authority will obtain the review and approval of the solicitation document, contract or agreement by the Department of Justice.
- (8) The terms and conditions of the contract to be awarded to a contractor selected using these source selection rules will be governed by the Public Contracting Code, except for interagency agreements or intergovernmental agreements exempt under ORS 279A.025(2), or contracts or agreements under other exemptions from the Public Contracting Code. The Public Contracting Code, if applicable, and such delegation of authority, if any, as may be made by the Department of Administrative Services to the Authority determine contract approval authority.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.115, 414.125, 414.135, 414.145 & 414.740