DHS Oregon Department of Human Services

Division of Medical Assistance Programs

General Rules Program

Rulebook

Includes:

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2) Current Update Information (changes since last update)

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4) Complete set of General Rules Program Administrative Rules

DEPARTMENT OF HUMAN SERVICES, DEPARTMENTAL ADMINISTRATION AND MEDICAL ASSISTANCE PROGRAMS

DIVISION 120

GENERAL RULES

Update Information (most current Rulebook changes)

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General Rules Program Rulebook

Update Information

for

July 1, 2009

DMAP updated the General Rules Rulebook with the following administrative rule changes:

Amended:

410-120-0000
410-120-1560
410-120-1570
410-120-1580
410-120-1600

Repealed:

410-120-1680
410-120-1700

Temporary to Permanent:

410-120-0027

DMAP amended 410-120-0000 to insert the revised definition for "Emergency Ambulance Transportation." DMAP amended or repealed the remainder of rules listed above as a coordination effort in provider appeals rules related to administrative reviews and contested case hearings. Text is condensed and clarified. Rule 410-120-1570, Claims Re-determinations, includes more detailed process steps regarding reviews. There is no change to existing policy, just a clarification of the type of claims eligible for re-determination.

Other text in the above rules is revised to improve readability and to take care of necessary "housekeeping" corrections.

The Table of Contents is updated.

DMAP permanently adopted 410-120-0027 with no changes except to add the date of permanent status to the bottom of the rule. DMAP

temporarily adopted this rule to reference the document, MMIS Alternative Process and Procedures, dated May 1, 2009 with Release #1, Pharmacy Payments During MMIS Enrollment Data Correction, effective retroactive to January 12, 2009; Release #2, MMIS transitional issues/temporary protocols, effective retroactive to January 16, 2009; and Release #3, Prepaid Health Plan Supplemental Payment Processing, effective May 1, 2009, included in rule by reference and found on the DHS Web page: http://www.oregon.gov/DHS/healthplan/tools_prov/mmis-altpro.pdf

If you have questions, contact a Provider Services Representative toll-free at 1-800-336-6016 or direct at 503-378-3697.

Other Provider Resources

DMAP has developed the following additional materials not found in this Rulebook to help you bill accurately and receive timely payment for your services.

Supplemental Information

The General Rules Supplemental Information booklet contains important information not found in the rulebook, including:

- ✓ Advance Directive ("Your Right to Make Health Care Decisions in Oregon")
- ✓ Medical Care ID information
- ✓ Benefit package information
- ✓ Medicaid Management Information System (MMIS)

Be sure to download a copy of the General Rules Supplemental Information booklet at:

http://www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html

Note: Check the Web page regularly for changes to the booklet.

Provider Contact Booklet

This booklet lists general information phone numbers, frequent contacts, phone numbers to use to request prior authorization, and mailing addresses.

Download the Provider Contact Booklet at:

http://www.dhs.state.or.us/healthplan/data_pubs/add_ph_conts.pdf

Other Resources

We have posted other helpful information, including provider announcements, at:

http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml

Medicaid Management Information System (MMIS)

See the Web page called: "Everything you need to know about the new MMIS" found at http://www.oregon.gov/DHS/healthplan/mmis.shtml

This Web page includes information about the new Provider Web Portal at:

https://www.or-medicaid.gov

And, instructions to use the new Provider Web Portal at:

www.oregon.gov/DHS/healthplan/webportal.shtml

410-120-0000 Acronyms and Definitions

Identification of acronyms and definitions within this rule specifically pertain to their use within the Department of Human Services (DHS), Division of Medical Assistance Programs (DMAP) administrative rules. This rule does not include an exhaustive list of DMAP acronyms and definitions. For more information, see DMAP Oregon Health Plan (OHP) program OAR 410-141-0000, Acronyms and Definitions, and any appropriate governing acronyms and definitions in DHS chapter 407 administrative rules, or contact DMAP.

(1) AAA - Area Agency on Aging.

(2) Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the DMAP, 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 DMAP.

(3) Acupuncturist - A person licensed to practice acupuncture by the relevant state licensing board.

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

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

(6) Acquisition cost - 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.

(7) Addiction and Mental Health Division (AMH) - A division within DHS that administers mental health and addiction programs and services.

(8) Adequate record keeping - Documentation that supports the level of service billed. See 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.

(9) Administrative medical examinations and reports - Examinations, evaluations, and reports, including copies of medical records, requested on

the DMAP 729 form through the local Department of Human Services (DHS) branch office or requested or approved by DMAP to establish client eligibility for a medical assistance program or for casework planning.

(10) Adverse event – An undesirable and unintentional, though not unnecessarily unexpected, result of medical treatment.

(11) All-inclusive rate - 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 DMAP 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.

(12) Allied agency – Local and regional governmental agency and regional authority that contracts with DHS 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).

(13) Ambulance - A specially equipped and licensed vehicle for transporting sick or injured persons which meets the licensing standards of DHS or the licensing standards of the state in which the ambulance provider is located.

(14) Ambulatory Surgical Center (ASC) - A facility licensed as an ASC by DHS.

(15) American Indian/Alaska Native (AI/AN) – 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.

(16) American Indian/Alaska Native (AI/AN) clinic – 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).

(17) Ancillary services - Services supportive of or necessary to the provision of a primary service (e.g., anesthesiology is an ancillary service necessary for a surgical procedure); Typically, such medical services are not identified in the definition of a condition/treatment pair, but are medically appropriate to support a service covered under the OHP benefit package; ancillary services and limitations are specified in the OHP (Managed Care) administrative rules related to the Oregon Health Services Commission's Prioritized List of Health Services (410-141-0480 through 410-141-0520), the General Rules Benefit Packages (410-120-1210), Exclusions (410-120-1200) and applicable individual program rules.

(18) Anesthesia services - Administration of anesthetic agents to cause loss of sensation to the body or body part.

(19) Atypical provider – Entity able to enroll as a Billing Provider (BP) or performing 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.

(20) Audiologist - A person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.

(21) Audiology - 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.

(22) Automated Voice Response (AVR) - A computer system that provides information on clients' current eligibility status from DMAP by computerized phone or Web-based response.

(23) Benefit Package - The package of covered health care services for which the client is eligible.

(24) Billing Agent or Billing Service -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.

(25) Billing provider (BP) - A person, agent, business, corporation, clinic, group, institution, or other entity who submits claims to and/or receives payment from DMAP on behalf of a performing provider and has been delegated the authority to obligate or act on behalf of the performing provider.

(26) Buying Up - The practice of obtaining client payment in addition to the DMAP or managed care plan payment to obtain a non-covered service or item. (See 410-120-1350 Buying Up)

(27) By Report (BR) - 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.

(28) Children, Adults and Families Division (CAF) – A division within DHS, responsible for administering self-sufficiency and child-protective programs.

(29) Children's Health Insurance Program (CHIP) - A federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by DMAP.

(30) Chiropractor - A person licensed to practice chiropractic by the relevant state licensing board.

(31) Chiropractic services - Services provided by a licensed chiropractor within the scope of practice, as defined under state law and Federal regulation.

(32) Citizen/Alien-Waived Emergency Medical (CAWEM) - 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).

(33) Claimant - a person who has requested a hearing.

(34) Client - A person who is currently receiving medical assistance (also known as a recipient).

(35) Clinical Social Worker - A person licensed to practice clinical social work pursuant to State law.

(36) Contiguous Area - The area up to 75 miles outside the border of the State of Oregon.

(37) Contiguous area provider - A provider practicing in a contiguous area.

(38) Co-payments - 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)

(39) Cost effective - The lowest cost health care service or item that, in the judgment of DMAP staff or its contracted agencies, meets the medical needs of the client.

(40) Current Dental Terminology (CDT) - A listing of descriptive terms identifying dental procedure codes used by the American Dental Association.

(41) Current Procedural Terminology (CPT) - 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.

(42) Date of receipt of a claim - The date on which DMAP 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.

(43) Date of service - 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.

(44) Dental emergency services - Dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.

(45) Dental Services - Services provided within the scope of practice as defined under state law by or under the supervision of a dentist.

(46) Dentist - 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.

(47) Denturist - A person licensed to practice denture technology pursuant to State law.

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

(49) Dental hygienist – A person licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to State law.

(50) Dental hygienist with Limited Access Certification (LAC) – A person licensed to practice dental hygiene with LAC pursuant to State law.

(51) Department – DHS or its Division of Medical Assistance Programs (DMAP).

(52) Department of Human Services (DHS) – The Department or DHS or any of its programs or offices means the Department of Human Services established in ORS Chapter 409, including such divisions, programs and offices as may be established therein. Wherever the former Office of Medical Assistance Programs or OMAP is used in contract or in administrative rule, it shall mean the Division of Medical Assistance Programs (DMAP). Wherever the former Office of Mental Health and Addiction Services or OMHAS is used in contract or in rule, it shall mean the Addictions and Mental Health Division (AMHD). Wherever the former Seniors and People with Disabilities or SPD is used in contract or in rule, it shall mean the Seniors and People with Disabilities Division (SPD). Wherever the former Children Adults and

Families or CAF is used in contract or rule, it shall mean the Children, Adults and Families Division (CAF). Wherever the former Health Division is used in Contract or in rule, it shall mean the Public Health Division (PHD).

(53) Department representative - A person who represents the Department and presents the position of the Department in a hearing.

(54) Diagnosis code - 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.

(55) Diagnosis Related Group (DRG) – A system of classification of diagnoses and procedures based on the ICD-9-CM.

(56) Division of Medical Assistance Programs (DMAP) - A division within DHS; DMAP 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.

(57) DMAP member -- An OHP Client enrolled with a PHP.

(58) Durable Medical Equipment, Prosthetics, Orthotics and and Medical Supplies (DMEPOS) - 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.

(59) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck) - 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 DMAP clients and their parents or guardians effectively use them.

(58) Electronic Data Interchange (EDI) – 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 Department designates for EDI transactions. For purposes of rules 407-120-0100 through 407-120-0200, EDI does not include electronic transmission by web portal.

(59) EDI submitter – An individual or an entity authorized to establish an electronic media connection with DHS to conduct and EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.

(60) Electronic Verification System (EVS) eligibility information that has met the legal and technical specifications of DMAP in order to offer eligibility information to enrolled providers of DMAP.

(61) Emergency department - The part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.

(62) Emergency medical condition - 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)).

(63) Emergency Medical transportation – 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.

(64) Evidence-based medicine- is 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))

(65) False claim - 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.

(66) Family planning services- 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.

(67) Federally Qualified Health Center (FQHC) - 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 a FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.

(68) Fee-for-service provider - A medical provider who is not reimbursed under the terms of a DMAP contract with a Prepaid Health Plan (PHP), also referred to as a Managed Care Organization (MCO). A medical provider

participating in a PHP may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP.

(69) Fraud – 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.

(70) Fully dual eligible – 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 DHS for full medical assistance coverage.

(71) General Assistance (GA) - Medical assistance administered and funded 100% with State of Oregon funds through OHP.

(72) Healthcare Common Procedure Coding System (HCPCS)- A method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level l - American Medical Association's Physician's Current Procedural Terminology (CPT), Level II - National codes, and Level III - Local codes. DMAP uses HCPCS codes; however, DMAP uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.

(73) Health Maintenance Organization (HMO) - 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.

(74) Hearing aid dealer - 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.

(75) Home enteral nutrition - 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.

(76) Home health agency - A public or private agency or organization which has been certified by Medicare as a Medicare home health agency and which is licensed by DHS as a home health agency in Oregon, and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.

(77) Home health services - 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.

(78) Home intravenous services - 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.

(79) Home parenteral nutrition - 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.

(80) Hospice – a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, is certified for Medicare, accredited by the Oregon Hospice Association, and is listed in the Hospice Program Registry.

(81) Hospital - A facility licensed by the Office of Public Health Systems as a general hospital which meets requirements for participation in the OHP under Title XVIII of the Social Security Act. DMAP does not consider facilities certified by the 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.

(82) Hospital-based professional services - 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 (DMAP 42) report for DMAP.

(83) Hospital laboratory - 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 DMAP.

(84) Indian Health Program – Any Indian health service facility, any Federally recognized Tribe or Tribal organization, or any FQHC with a 638 designation.

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

(86) Inpatient hospital services - Services that are furnished in a hospital for the care and treatment of an inpatient. (See DMAP Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)

(87) Institutional Level of Income Standards (ILIS) - 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.

(88) Institutionalized - 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.

(89) International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (including volumes 1, 2, and 3, as revised annually).– A book of diagnosis codes used for billing purposes when

treating and requesting reimbursement for treatment of diseases. (92) Laboratory - 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).

(90) Laboratory services - 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.

(91) Licensed Direct Entry Midwife - A practitioner who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery by the DHS Public Health Division.

(92) Liability insurance - 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.

(93) Managed Care Organization (MCO) – 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).

(94) Maternity Case Management - 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 DMAP Medical-Surgical Services program administrative rules.

(95) Medicaid - 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 DHS.

(96) Medical assistance eligibility confirmation - Verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized DHS representative.

(97) Medical services - Care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating or correcting a medical problem.

(98) Medical transportation - Transportation to or from covered medical services.

(99) Medically appropriate - 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 an DMAP client or Primary Care Manager (PCM) Member in the PHP's or PCM’s judgment.

(100) Medicare - 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) - 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 DMAP Pharmaceutical Services program administrative rules in chapter 410, division 121.

(101) Medicheck for Children and Teens – 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 DMAP clients and their parents or guardians effectively use them.

(102) National Provider Identification (NPI) – 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.

(103) Naturopath - A person licensed to practice naturopathy pursuant to State law.

(104) Naturopathic services - Services provided within the scope of practice as defined under State law.

(105) Non-covered services - Services or items for which DMAP 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 DMAP administrative rules.

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

(107) Nurse Practitioner - A person licensed as a registered nurse and certified by the Board of Nursing to practice as a Nurse Practitioner pursuant to State law.

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

(109) Nursing facility - A facility licensed and certified by the DHS SPD and defined in OAR 411-070-0005.

(110) Nursing services - 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.

(111) Nutritional counseling - 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.

(112) Occupational Therapist - A person licensed by the State Board of Examiners for Occupational Therapy.

(113) Occupational Therapy - 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.

(114) Optometric services - Services provided, within the scope of practice of optometrists as defined under State law.

(115) Optometrist - A person licensed to practice optometry pursuant to State law.

(116) Oregon Youth Authority (OYA) - 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.

(117) Out-of-State providers - 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.

(118) Outpatient hospital services - Services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see DMAP Hospital Services administrative rules found in chapter 410, division 125.

(119) Overdue claim - A valid claim that is not paid within 45 days of the date it was received.

(120) Overpayment - Payment(s) made by DMAP to a Provider in excess of the correct DMAP payment amount for a service. Overpayments are subject to repayment to DMAP.

(121) Overuse - Use of medical goods or services at levels determined by DMAP medical staff and/or medical consultants to be medically unnecessary or potentially harmful.

(122) Panel - The Hearing Officer Panel established by section 3, chapter 849, Oregon Laws 1999.

(123) Payment Authorization - Authorization granted by the responsible DHS 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.

(124) Peer Review Organization (PRO) – 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.

(125) Pharmaceutical Services - 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.

(126) Pharmacist - A person licensed to practice pharmacy pursuant to state law.

(127) Physical Capacity Evaluation - 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.

(128) Physical Therapist - A person licensed by the relevant State licensing authority to practice Physical Therapy.

(129) Physical Therapy - 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.

(130) Physician - 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.

(131) Physician Assistant - 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.

(132) Physician Services - Services provided, within the scope of practice as defined under state law, by or under the personal supervision of a Physician.

(133) Podiatric Services - Services provided within the scope of practice of Podiatrists as defined under state law.

(134) Podiatrist - A person licensed to practice podiatric medicine pursuant to state law.

(135) Post-Payment Review - 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.

(136) Practitioner - 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.

(137) Premium Sponsorship - Premium donations made for the benefit of one or more specified DMAP Clients (See 410-120-1390).

(138) Prepaid Health Plan (PHP) – A managed health, dental, chemical dependency, or mental health organization that contracts with DMAP and/or AMH on a case managed, prepaid, capitated basis under OHP. PHP’s 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)

(139) Primary Care Physician - A Physician who has responsibility for supervising, coordinating and providing initial and primary care to patients, initiating Referrals for consultations and specialist care, and maintaining the continuity of patient care.

(140) Primary Care Provider (PCP) - 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.

(141) Prior Authorization (PA) - Payment Authorization for specified Medical Services or items given by DMAP staff, or its contracted agencies prior to provision of the service. A Physician Referral is not a PA.

(142) Prioritized List of Health Services – Also referred to as the Prioritized List, the Oregon Health Services Commission's (HSC) listing of health services with "expanded definitions" of Ancillary Services and Preventive Services and the HSC practice guidelines, as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HSC. The Prioritized List governs medical assistance programs' health services and Benefit Packages pursuant to these General Rules (OAR 410-120-0000 et seq.) and OAR 410-141-0480 through 410-141-0520.

(143) Private Duty Nursing Services - 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.

(144) Provider - An individual, facility, institution, corporate entity, or other organization which supplies health care services or items, also termed a performing Provider, or bills, obligates and receives reimbursement on behalf of a performing Provider of services, also termed a Billing Provider (BP). The term Provider refers to both Performing Providers and BP(s) unless otherwise specified.

(145) Provider Organization – 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 DHS, 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)

(146) Public Health Clinic - A clinic operated by county government.

(147) Public Rates - 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 DMAP Clients.

(148) Qualified Medicare Beneficiary (QMB) - A Medicare beneficiary, as defined by the Social Security Act and its amendments.

(149) Qualified Medicare and Medicaid Beneficiary (QMM) - A Medicare Beneficiary who is also eligible for DMAP coverage.

(150) Quality Improvement Organization (QIO) – 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.

(151) Radiological Services - 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.

(152) Recipient - A person who is currently eligible for medical assistance (also known as a Client).

(153) Recreational therapy- recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).

(154) Recoupment - An accounts receivable system that collects money owed by the Provider to DMAP by withholding all or a portion of a Provider's future payments.

(155) Referral - The transfer of total or specified care of a Client from one Provider to another. As used by DMAP, 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 DMAP.

(156) Remittance Advice (RA) - The automated notice a Provider receives explaining payments or other claim actions. It is the only notice sent to Providers regarding claim actions.

(157) Request for Hearing - A clear expression, in writing, by an individual or representative that the person wishes to appeal a Department decision or action and wishes to have the decision considered by a higher authority.

(158) Retroactive Medical Eligibility - Eligibility for medical assistance granted to a Client retroactive to a date prior to the Client's application for medical assistance.

(159) Sanction - An action against Providers taken by DMAP in cases of Fraud, misuse or Abuse of DMAP requirements.

(160) School Based Health Service - 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.

(161) Seniors and People with Disabilities Division (SPD) - An Office of DHS responsible for the administration of programs for seniors and people with disabilities.

(162) Service Agreement - An agreement between DMAP 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.

(163) Sliding Fee Schedule - 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.

(164) Social Worker - A person licensed by the Board of Clinical Social Workers to practice clinical social work.

(165) Speech-Language Pathologist - A person licensed by the Oregon Board of Examiners for Speech Pathology.

(166) Speech-Language Pathology Services - 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.

(167) Spend-Down - The amount the Client must pay for medical expenses each month before becoming eligible for medical assistance under the Medically Needy Program. The spend-down is equal to the difference between the Client's total countable income and Medically Needy program income limits.

(168) State Facility - A Hospital or training center operated by the State of Oregon, which provides long-term medical or psychiatric care.

(169) Subparts (of a Provider Organization) – 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.

(170) Subrogation - Right of the State to stand in place of the Client in the collection of Third Party Resources (TPR).

(171) Supplemental Security Income (SSI) - A program available to certain aged and disabled persons which is administered by the Social Security Administration through the Social Security office.

(172) Surgical Assistant - A person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(173) Suspension - A Sanction prohibiting a Provider's participation in DHS medical assistance programs by deactivation of the Provider's DMAP 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.

(174) Targeted Case Management (TCM)- 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 often provided by Allied Agency Providers.

(175) Termination - A Sanction prohibiting a Provider's participation in DMAP’s programs by canceling the Provider's DMAP 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 DMAP at the time of Termination.

(176) Third Party Resource (TPR) - A medical or financial resource which, under law, is available and applicable to pay for Medical Services and items for a DMAP Client.

(177) Transportation - See Medical Transportation.

(178) Type A Hospital - A Hospital identified by the Office of Rural Health as a Type A Hospital.

(179) Type B AAA Unit - A Type B Area Agency on Aging (AAA) funded by Oregon Project Independence (OPI), Title III - Older Americans Act, and Title XIX of the Social Security Act.

(180) Type B Hospital - A Hospital identified by the Office of Rural Health as a Type B Hospital.

(181) Usual Charge (UC) - 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.

(182) Utilization Review (UR) - 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.

(183) Valid Claim - An invoice received by DMAP or the appropriate 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).

(184) Vision Services - Provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

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

Stats. Implemented: ORS 414.065

7-1-09

410-120-0025 Administration of Division of Medical Assistance Programs, Regulation and Rule Precedence

(1) The Department of Human Services (DHS) and its Division of Medical Assistance Programs (DMAP), may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of medical assistance programs including the Oregon Health Plan pursuant to ORS 414.065 (generally, fee-for-service), ORS 414.725 (Prepaid Health Plans), and ORS 414.115 to 414.145 (services contracts) subject to the rulemaking requirements of Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.

(2) In applying its policies, procedures, rules and interpretations, DMAP will construe them as much as possible to be complementary. In the event that DMAP policies, procedures, rules and interpretations may not be complementary, DMAP will apply the following order of precedence to guide its interpretation:

(a) For purposes of the provision of covered medical assistance to DMAP Clients, including but not limited to authorization and delivery of service, or denials of authorization or services, DMAP, Clients, enrolled Providers and the Prepaid Health Plans will apply the following order of precedence:

(A) Those federal laws and regulations governing the operation of the medical assistance program and any waivers granted DMAP by the Centers for Medicare and Medicaid Services to operate medical assistance programs including the Oregon Health Plan;

(B) Oregon Revised Statutes governing medical assistance programs;

(C) Generally for Prepaid Health Plans, requirements applicable to the provision of covered medical assistance to DMAP Clients are provided in OAR 410-141-0000 through 410-141-0860, Oregon Health Plan Administrative Rules for Prepaid Health Plans, inclusive, and where applicable, DMAP General Rules, OAR 410-120-0000 through 410-120-1980, and the Provider rules applicable to the category of medical service;

(D) Generally for enrolled fee-for-service Providers or other contractors, requirements applicable to the provision of covered medical assistance to

DMAP Clients are provided in DMAP General Rules, OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage described in OAR 410-141-0480 to 410-141-0520, and the Provider rules applicable to the category of medical service;

(E) Any other applicable duly promulgated rules issued by DMAP and other offices or units within the Department of Human Services necessary to administer the State of Oregon's medical assistance programs, such as Electronic Data transaction Rules in OAR 407-120-0100 to 407-120-0200; and

(F) The basic framework for provider enrollment in OAR 407-120-0300 through 407-120-0380 generally apply to providers enrolled with DHS, subject to more specific requirements applicable to the administration of the Oregon Health Plan and medical assistance programs administered by DMAP. For purposes of this rule, "more specific" means the requirements, laws and rules applicable to the provider type and covered services described in subsections (A) – (E) of this section.

(b) For purposes of contract administration solely as between DMAP and its Prepaid Health Plans, the terms of the applicable contract and the requirements in subsection (2)(a) of this rule applicable to the provision of covered medical assistance to DMAP Clients.

(A) Nothing in this rule shall be deemed to incorporate into contracts provisions of law not expressly incorporated into such contracts, nor shall this rule be deemed to supercede any rules of construction of such contracts that may be provided for in such contracts.

(B) Nothing in this rule gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly or indirectly or otherwise, to any person or entity unless such person or entity is identified by name as a named party to the contract.

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

3-14-08 (T) 5-1-08 (P)

410-120-0027 MMIS Alternative Process and Procedure

(1) Consistent and in accordance with OAR 407-120-0400 DHS MMIS Replacement Communication Plan, follow criteria outlined in the "MMIS Alternative Process and Procedures", dated January 12, 2009 with Release #1, Pharmacy Payments During MMIS Enrollment Data Correction, dated January 12, 2009, Release #2, MMIS transitional issues/temporary protocols, dated January 16, 2009 and Release #3 Prepaid Health Plan Supplemental Payment Processing included in rule by reference and found on the DHS Web page:
http://www.oregon.gov/DHS/healthplan/tools_prov/mmis-altpro.pdf.

(2) This rule and the information found in the referenced documents take precedence over existing rules in Chapter 410.

Statutory Authority: ORS Stat. Auth.: ORS 409.025, 409.040, 409.050, 409.110 & 414.065
Other Authority: None
Statutes Implemented: ORS 414.065

5-1-09 (T) 7-1-09 (P)

410-120-0030 Children's Health Insurance Program (SCHIP)

(1) The Children's Health Insurance Program (SCHIP) is a federal non-entitlement program for children under 19 years of age that provides health coverage for uninsured, low-income children who are ineligible for Medicaid and meet the SCHIP eligibility requirements. The SCHIP program is administered by the Department of Human Services (DHS) in accordance with the Oregon Health Plan waiver and the SCHIP state plan. The General Rules (OAR 410-120-0000 et. seq.) and Oregon Health Plan Rules (OAR 410-141-0000 et. seq.) applicable to the Medicaid program are also applicable to the DHS SCHIP program.

(2) Eligibility criteria, including but not limited to income methodologies and citizenship requirements for medical assistance applicable to children under the age of 19 years, are established in OAR Chapter 461 through the program acronym OHP-CHP.

(3) Benefit package of covered services: Children determined eligible for SCHIP receive the same OHP Plus benefits as covered under Medicaid categorically needy program. (For benefits refer to 410-120-1210).

(4) SCHIP Pilot project – Prenatal coverage for CAWEM under SCHIP:

(a) Notwithstanding subsections (2) and (3) of this rule, CAWEM pregnant women residing in Multnomah County or Deschutes County during pregnancy who participate in the SCHIP pilot project will receive expanded medical services (OHP Plus benefit package, as limited under subsection (d) of this subsection) to provide prenatal care for the unborn child and labor and delivery services through this pilot program;

(b) This population is exempt from managed care enrollment. The preferred service delivery system will be Primary Care Management (PCM). Fee-For-Service (FFS) enrollment will be available by exception for continuity of care or other DHS-approved reasons that could justify disenrollment from a PCM under OAR 410-141-0085;

(c) Pilot project services continue through labor and delivery. 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 the pilot project:

(i) Postpartum care beyond the global payment;

(ii) Sterilization;

(iii) Abortion;

(iv) Death with dignity services;

(v) Hospice.

Stat. Auth.: ORS 409.010, 409.110, 409.050
Stats. Implemented: ORS 414.065

04-1-08 (T) 7-1-08 (P)

410-120-0035 Public Entity

(1) This rule pertains to Centers for Medicare and Medicaid (CMS) regulations for payments to and from Department of Human Services (DHS) and public entities.

(2) Effective July 1, 2008, unit of government providers responsible by rule or contract for the local match share portion for claims eligible for Federal Financial Participation (FFP) submitted to Medicaid for reimbursement must submit the local match payment prior to DHS claiming the federal share from CMS:

(a) Before the Department makes payment to the provider that submits its claims to DHS, the provider must transfer funds from allowable sources to DHS representing the local match share of the total allowable cost for claimed services;

(b) Upon receipt of provider's transfer of the local match share and the DHS receipt of claims in the Medicaid Management Information System (MMIS) that are reimbursable to the extent of the transferred local match share amount, DHS will claim FFP from CMS and reimburse the provider for the total reimbursable allowable claimed amount for the services;

(c) Transfer of the local match share to DHS means that the provider certifies that for the purposes of 42 CFR 433.51, the funds it transfers to DHS for the local match share are public funds that are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds; and that all sources of funds are allowable under 42 CFR 433 Subpart B.

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

7-1-08 (T) 9-15-08 (P)

410-120-0250 Managed Care Organizations

(1) The Department of Human Services (DHS) provides some Oregon Health Plan (OHP) Clients with prepaid health services, through contracts with a Prepaid Health Plan (PHP), also known as a Managed Care Organization (MCO). An MCO may be a Fully Capitated Health Plan (FCHP), Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO) or Physician Care Organization (PCO).

(2) The MCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law, the MCO's contract with DHS and the OHP Administrative Rules governing PHPs (OAR 410 Division 141).

(3) All MCOs are required to provide benefit coverage pursuant to OAR 410-120-1210 and 410-141-0480 through 410-141-0520, however, authorization criteria may vary between MCOs. It is the Providers' responsibility to comply with the MCO's Prior Authorization requirements or other policies necessary for reimbursement from the MCO, before providing services to any OHP Client enrolled in a MCO.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-120-1140 Verification of Eligibility and Coverage

(1) Providers are responsible to verify a person is an Oregon Health Plan (OHP) client with appropriate benefits prior to providing services in order to ensure reimbursement of services rendered. Providers assume full financial responsibility in serving a person who the provider did not confirm with the Division of Medical Assistance Programs (DMAP), is an OHP client who, on the date(s) of service, is enrolled in a benefit package that covers the services rendered.

(2) The standard DHS Medical Care Identification (ID) is printed on heavy paper the size of a business card listing the client's name, prime number and the date the ID was issued. When a person presents with this ID it does not guarantee that the person is an OHP client on that date of service.

(3) Providers must verify eligibility for reimbursement by verifying that the person is an OHP client and that the OHP client is in the appropriate benefit package to cover the services rendered. The ID does not guarantee that all services are covered services and will be reimbursed for this particular client. Providers must verify the client is eligible for OHP and has a benefit package that covers the service through one of the following (see the DMAP General Rules Supplemental Information guide for instructions):

(a) The DMAP MMIS Provider Web portal;

(b) The Automated Voice Response (AVR);

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

(4) The client may present with a business card size ID printed on lighter paper in case of misplaced originals. This "temporary" ID must be treated the same as the standard ID. Providers must verify eligibility.

(5) The client may also present with a temporary or emergency ID. For purposes of this rule, a temporary medical care identification is the DMAP FORM 1086. This temporary ID is a full page paper form showing beginning and ending dates of coverage. This temporary ID is issued if the client needs immediate care but their information is not yet entered into the automated system for provider's use. This temporary ID does guarantee

eligibility for the dates and benefit package indicated on the ID. Providers must honor the temporary ID until the information is available in the automated system.

Stat. Auth.: ORS 409.010, 409.110 & 409.050

Stats. Implemented: ORS 414.065, 414.025, 414.047

12-01-08

410-120-1160 Medical Assistance Benefits and Provider Rules

(1) Providers enrolled with and seeking reimbursement for services through the Division of Medical Assistance Programs (DMAP) 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 DMAP Administrative Rules are posted on the Department of Human Services (DHS) Web page for DMAP 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 DMAP Client's benefit package of health care services, when medically or dentally appropriate and within the limitations established by DMAP 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 Provider rules (OAR 410 Division 130);

(b) Administrative Examinations, as described in the Administrative

Examinations and Billing Services Provider rules (OAR 410 Division 150);

(c) Alcohol and drug abuse treatment services:

(A) DMAP covers alcohol and drug Inpatient Services for medical detoxification when provided in an acute care Hospital and when hospitalization is considered Medically Appropriate;

(B) DMAP 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 managed care plan if enrolled, the community mental health program (CMHP), an outpatient alcohol and drug treatment provider, the residential treatment program or OMHAS.

(d) Ambulatory Surgical Center Services, as described in the Medical-

Surgical Services Provider rules (OAR 410 Division 130);

(e) Anesthesia Services, as described in the Medical-Surgical Services Provider rules (OAR 410 Division 130);

(f) Audiology Services, as described in the Speech-Language Pathology, Audiology and Hearing Aid Services Provider rules (OAR 410 Division 129);

(g) Chiropractic Services, as described in the Medical-Surgical Services Provider rules (OAR 410 Division 130);

(h) Dental Services, as described in the Dental/Denturist Services Provider rules (OAR 410 Division 123);

(i) Early and Periodic Screening, Diagnosis and Treatment services

(EPSDT, Medicheck for children and teens), are covered for individuals under 21 years of age as set forth in the individual program Provider rules. DMAP 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 Provider rules (OAR 410 Division 130);

(k) Federally Qualified Health Centers and Rural Health Clinic, as described in the Federally Qualified Health Center and Rural Health Clinic Provider rules (OAR 410 Division 147);

(l) Home and Community Based Waiver Services, as described in the DHS 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 Provider rules (OAR

410 Division 148), and related Durable Medical Equipment and Medical Supplies rules (OAR 410 Division 122) and Pharmacy rules (OAR 410 Division 121);

(n) Home Health Services, as described in the Home Health Services Provider rules (OAR 410 Division 127);

(o) Hospice Services, as described in the Hospice Services Provider rules (OAR 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 DMAP American Indian/Alaska Native Provider rules (OAR 410 Division 146);

(q) Inpatient Hospital Services, as described in the Hospital Services Provider rules (OAR 410 Division 125);

(r) Laboratory Services, as described in the Hospital Services (OAR 410 Division 125) and the Medical-Surgical Services Provider rules (OAR 410 Division 130);

(s) Licensed Direct Entry Midwife Services, as described in the Medical-Surgical Services Provider rules (OAR 410 Division 130);

(t) Maternity Case Management, as described in the Medical-Surgical Services Provider rules (OAR 410 Division 130);

(u) Medical Equipment and Supplies, as described in the Hospital Services, Medical-Surgical Services, Durable Medical Equipment, Home Health Care Services, Home Enteral/Parenteral Nutrition and IV Services and other Provider rules;

(v) When a Client's Medical Care Identification Card indicates that he or she has a benefit package that includes mental health, the mental health services provided will be based on the Prioritized List of Health Services.;

(w) Naturopathic Services, as described in the Medical-Surgical Services Provider rules (OAR 410 Division 130);

(x) Nutritional Counseling as described in the Medical/Surgical Services Provider rules (OAR 410 Division 130);

(y) Occupational Therapy, as described in the Physical and Occupational Therapy Services Provider rules (OAR 410 Division 131);

(z) Organ Transplant Services, as described in the Transplant Services Provider rules (OAR 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 Provider rules (OAR 410 Division 125);

(bb) Physician, Podiatrist, Nurse Practitioner and Licensed Physician Assistant Services, as described in the Medical-Surgical Services Provider rules (OAR 410 Division 130);

(cc) Physical Therapy, as described in the Physical and Occupational Therapy and the Hospital Services Provider rules (OAR 410 Division 131);

(dd) Post Hospital Extended Care Benefit, as described in OAR 410 Division 120 and141 and SPD program rules;

(ee) Prescription drugs, including home enteral and parenteral nutritional services and home intravenous services, as described in the Pharmaceutical Services (OAR 410 Division 121), the Home Enteral/Parenteral Nutrition and IV Services (OAR 410 Division 148) and the Hospital Services Provider rules (OAR 410 Division 125);

(ff) Preventive Services, as described in the Medical-Surgical Services (OAR 410 Division 130) and the Dental/Denturist Services Provider rules (OAR 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 Provider rules (OAR 410 Division 132);

(hh) Radiology and Imaging Services, as described in the Medical-Surgical Services (OAR 410 Division 130), the Hospital Services (OAR 410 Division 125), and Dental and Denturist Services Provider rules (OAR 410 Division 123);

(ii) Rural Health Clinic Services, as described in the Federally Qualified Health Center and Rural Health Clinic Provider rules (OAR 410 Division 147);

(jj) School-Based Health Services, as described in the School-Based Health Services Provider rules (OAR 410 Division 133);

(kk) Speech and Language Therapy as described in the Speech-Language Pathology, Audiology and Hearing Aid Services (OAR 410 Division 129) and Hospital Services Provider rules (OAR 410 Division 125);

(ll) Transportation necessary to access a covered medical service or item, as described in the Medical Transportation Provider rules (OAR 410 Division 136);

(mm) Vision Services as described in the Visual Services Provider rules (OAR 410 Division 140).

(3) Other DHS units or Offices, including Vocational Rehabilitation, OMHAS, and SPD may offer services to Medicaid eligible Clients, which are not reimbursed by or available through DMAP.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-120-1180 Medical Assistance Benefits: Out-of-State Services

(1) Out-of-State Providers must enroll with the Department of Human Services as described in Oregon Administrative Rules (OAR) 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) DMAP reimburses enrolled Out-of-State Providers in the same manner and at the same rates as in-state Providers unless otherwise specified in the individual Provider rules or by contract or Service Agreement with the individual Provider.

(3) For enrolled non-contiguous, Out-of-State Providers, DMAP reimburses for covered services under any of the following conditions:

(a) The service 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) DMAP 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 was authorized by a Prepaid Health Plan (PHP) including a Fully Capitated Health Plan (FCHP), a Physician Care Organization (PCO) or a Dental Care Organization (DCO) and payment to the Out-of-State Provider is the responsibility of the PHP;

(e) The service is being billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage.

(4) DMAP 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) DMAP 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 DMAP (or, for those Clients covered by a managed care plan, the plan will make that determination); and

(d) The service or item is deemed Medically Appropriate and is recommended by a referring Oregon Physician;

(e) If a Client has coverage through a managed care plan, a PHP, the request for non-emergency services must be referred to the PHP. Payment for these services is the responsibility of the PHP.

(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 DMAP rules.

(6) DMAP makes no reimbursement for services provided to a Client outside the territorial limits of the United States, unless the country operates a Title XIX medical assistance program.

(7) DMAP 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 Department of Human Services (DHS) has placed in foster care;

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

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

(8) DMAP 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 409.010, 409.025, 409.040, 409.050, 409.110

Stats. Implemented: ORS 414.065, 414.019, 414.025,

12-1-08

410-120-1190 Medically Needy Benefit Program

The Medically Needy Program is eliminated effective February 1, 2003. Although references to this benefit exist elsewhere in rule, the program currently is not funded and is not offered as a benefit.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
1-1-07

410-120-1195 SB 5548 Population

(1) Certain individuals previously participating in the OSIP-MN Medically Needy Program as of January 31, 2003, and who are identified by the Department of Human Services (DHS) with specific health-related conditions as outlined in the Joint Ways and Means budget note accompanying Senate Bill 5548 (2003) shall be referred to as SB 5548 Clients.

(2) SB 5548 Clients are eligible for a State-funded, limited, prescription drug benefit for covered drugs described in subsection (3) of this rule.

(3) Eligibility for, and access to, covered drugs for SB 5548 Clients:

(a) SB 5548 Clients must have been participating in the former OSIP-MN Medically Needy Program as of January 31, 2003, and as of that date had a medical diagnosis of HIV or organ transplant status;

(b) SB 5548 Clients receiving anti-retroviral and other prescriptions necessary for the direct support of HIV symptoms:

(A) Must agree to participate in the DHS CareAssist Program in order to obtain access to this limited prescription drug benefit; and

(B) Prescriptions are limited to those listed on the CareAssist Formulary which can be found at www.dhs.state.or.us/publichealth/hiv/careassist/frmlry.cfm.

(c) SB 5548 Clients receiving prescriptions necessary for the direct support of organ transplants are limited:

(A) Drug coverage includes any Medicaid reimbursable immunosuppressive, anti-infective or other prescriptions necessary for the direct support of organ transplants.

(B) Some drug classes are subject to restrictions or limitations based upon the Practitioner-Managed Prescription Drug Plan, OAR 410-121-0030.

(4) Reimbursement for covered prescription drugs is limited by the terms and conditions described in this rule. This limited drug benefit provides State-funded reimbursement to pharmacies choosing to participate according to the terms and conditions of this rule:

(a) DHS will send SB 5548 Clients a letter from the Department, instead of a Medical Care Identification, which will document their eligibility for this limited drug benefit;

(b) Retail pharmacies choosing to participate will be reimbursed for covered prescription drugs for the direct support of organ transplants described in subsection (3)(c) of this rule at the lesser of billed, Average Wholesale Price (AWP) minus 15% or Oregon Maximum Allowable Cost (OMAC), plus a dispensing fee of $3.50;

(c) DHS pharmacy benefits manager, will process retail pharmacy drug benefit reimbursement claims for SB 5548 Clients;

(d) Mail order reimbursement will be subject to DHS contract rates;

(e) Prescription drugs through the CareAssist program will be subject to the DHS contract rates;

(f) Reimbursement for this limited drug benefit is not subject to the following rules:

(A) 410-120-1230, Client Copayments;

(B) 410-121-0300, Federal Upper Limit (FUL) for prescription drugs.

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050, 409.110,

Stats. Implemented: ORS 414.019, 414.025, 414.065,

12-01-08

410-120-1200 Excluded Services and Limitations

(1) Certain services or items are not covered under any program or for any group of eligible Clients. If the Client accepts financial responsibility for a Non-Covered Service, payment is a matter between the Provider and the Client subject to the requirements of OAR 410-120-1280.

(2) The Division of Medical Assistance Programs (DMAP) will make no payment for any expense incurred for any of the following services or items that are:

(a) Not expected to significantly improve the basic health status of the Client as determined by DMAP staff, or its contracted entities, for example, the DMAP Medical Director, medical consultants, dental consultants or Quality Improvement Organizations (QIO);

(b) Not reasonable or necessary for the diagnosis and treatment of disability, illness, or injury;

(c) Determined not medically or dentally appropriate by DMAP staff or authorized representatives, including Acumentra or any contracted Utilization Review organization;

(d) Not properly prescribed as required by law or administrative rule by a licensed practitioner practicing within his or her scope of practice or licensure;

(e) For routine checkups or examinations for individuals age 21 or older in connection with participation, enrollment, or attendance in a program or activity not related to the improvement of health and rehabilitation of the Client. Examples include exams for employment or insurance purposes;

(f) Provided by friends or relatives of eligible Clients or members of his or her household, except when the friend, relative or household member:

(A) Is a health professional, acting in a professional capacity; or

(B) Is directly employed by the Client under the Department of Human Services (DHS) Seniors and People with Disabilities Division (SPD) Home

and Community Based Waiver or the SPD administrative rules, OAR 411-034-000 through 411-034-0090, governing Personal Care Services covered by the State Plan; or

(C) Is directly employed by the Client under the Children, Adults and Families Division (CAF) administrative rules, OAR 413-090-0100 through 413-090-0220, for services to children in the care and custody of the Department who have special needs inconsistent with their ages. A family member of a minor Client (under the age of 18) must not be legally responsible for the Client in order to be a Provider of personal care services;

(g) For services or items provided to a Client who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, except such services as designated by federal statute or regulation as permissible for coverage under DMAP administrative rules;

(h) Needed for purchase, repair or replacement of materials or equipment caused by adverse actions of Clients to personally owned goods or equipment or to items or equipment that DMAP rented or purchased;

(i) Related to a non-covered service; some exceptions are identified in the individual Provider rules. If DMAP determines the provision of a service related to a non-covered service is cost-effective, the related medical service may, at the discretion of DMAP and with DMAP Prior Authorization (PA), be covered;

(j) Considered experimental or investigational, including clinical trials and demonstration projects, or which deviate from acceptable and customary standards of medical practice or for which there is insufficient outcome data to indicate efficacy;

(k) Identified in the appropriate program rules including the Hospital rules, Revenue Codes Section, as Non- Covered Services.

(l) Requested by or for a Client whom DMAP has determined to be non-compliant with treatment and who is unlikely to benefit from additional related, identical, or similar services;

(m) For copying or preparing records or documents that except those Administrative Medical Reports requested by the branch offices or DMAP for casework planning or eligibility determinations;

(n) Whose primary intent is to improve appearances;

(o) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the Client will be essentially the same;

(p) For the purpose of establishing or reestablishing fertility or pregnancy or for the treatment of sexual dysfunction, including impotence,

(q) Items or services which are for the convenience of the Client and are not medically or dentally appropriate;

(r) The collection, processing and storage of autologous blood or blood from selected donors unless a Physician certifies that the use of autologous blood or blood from a selected donor is Medically Appropriate and surgery is scheduled;

(s) Educational or training classes that are not Medically Appropriate (Lamaze classes, for example);

(t) Outpatient social services except Maternity Case Management services and other social services described as covered in the individual Provider rules;

(u) Plasma infusions for treatment of Multiple Sclerosis;

(v) Post-mortem exams or burial costs, or other services subsequent to the death of a Client;

(w) Radial keratotomies;

(x) Recreational therapy;

(y) Telephone calls covered only as specified for:

(A) Tobacco cessation counseling, as described in OAR 410-130- 0190;

(B) Maternity Case Management as described in OAR 410-130-0595;

(C) Telemedicine as described in OAR 410-130-0610; and

(D) Services specifically identified as allowable for telephonic delivery when appropriate in the Mental Health and Chemical Dependency procedure code and reimbursement rates published by the DHS Addiction and Mental Health Division;

(z) Transsexual surgery or any related services or items;

(aa) Weight loss programs, including, but not limited to Optifast,Nutrisystem, and other similar programs. Food supplements will not be authorized for use in weight loss;

(bb) Whole blood (whole blood is available at no cost from the Red Cross); the processing, storage and costs of administering whole blood are covered;

(cc) Immunizations prescribed for foreign travel;

(dd) Services that are requested or ordered but not provided (i.e., an appointment which the Client fails to keep or an item of equipment which has not been provided to the Client);

(ee) DUII-related services already covered by the Intoxicated Driver Program Fund as directed by ORS 813.270(1) and (5);

(ff) Transportation to meet a Client's personal choice of a Provider;

(gg) Pain center evaluation and treatment;

(hh) Alcoholics Anonymous (AA) and other self help programs;

(ii) Medicare Part D covered prescription drugs or classes of drugs, and any cost sharing for those drugs, for Medicare-Medicaid Fully Dual Eligible

Clients, even if the Fully Dual Eligible Client is not enrolled in a Medicare Part D plan. See OAR 410-120-1210 for Benefit Package.

Stat. Auth.: ORS 409.010, 409.110, 409.065 & 409.050

Stats. Implemented: ORS 414.065, 414.025

7-1-08

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. The letters in field 9b “Benefit Packages” of the Medical Care ID identify each Client’s Benefit Package. Some medical assistance Clients have limited benefits. The text in the box marked “Benefit Package Messages,” on the Medical Care Identification, describe the package of medical benefits the Recipient is eligible to receive.

(2) The Division of Medical Assistance Programs (DMAP) Benefit Package names, and the Clients eligible to receive the various packages, are identified as follows:

(a) Oregon Health Plan (OHP) Plus Benefit Package - Clients on this Benefit Package are categorically eligible for medical assistance as defined in federal regulations and in the OHP waiver granted on October 15, 2002. 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 and also meets Department of Human Services’ (DHS) adopted income and other eligibility criteria;

(b) Qualified Medicare Beneficiary (QMB) + OHP with limited drug Benefit Package - Clients on this Benefit package are Medicare beneficiaries who meet DHS adopted income standard and other eligibility criteria for full medical assistance coverage, and are Fully Dual Eligible for purposes of Medicare Part D; DHS identifies these Clients through the Benefit Package identifier BMM;

(c) OHP with limited drug Benefit Package – Clients on this Benefit Package are Medicare beneficiaries, other than QMBs in (2)(b) of this rule, who meet DHS adopted income standard and other eligibility criteria for full medical assistance coverage, and are Fully Dual Eligible for purposes of Medicare Part D; DHS identifies these Clients through the Benefit Package identifier BMD;

(d) OHP Standard Benefit Package - Clients on this Benefit Package are eligible for OHP through the Medicaid expansion waiver granted on October 15, 2002. These Clients are adults and childless couples who meet DHS adopted income and other eligibility criteria; DHS identifies these Clients through the program acronym, OHP-OPU;

(e) Qualified Medicare Beneficiary (QMB)-Only Benefit Package - Clients on this limited Benefit Package are Medicare beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage. These Clients have coverage through Medicare Parts A and B for most covered services;

(f) Citizen/Alien-Waived Emergency Medical (CAWEM) Benefit Package - Clients on this limited Benefit Package are certain eligible, non-qualified aliens that are not eligible for other Medicaid programs pursuant to Oregon Administrative Rules (OAR) 461-135-1070. The Medical Care Identification that the Client is issued indicates coverage. The CAWEM Benefit Package is limited to the services listed in section (3)(f) of this rule.

(3) The benefit limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in individual program Provider rules. The benefits and limitations included in each OHP Benefit Package follow:

(a) OHP Plus Benefit Package coverage includes:

(A) 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);

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

(C) Chemical dependency services provided through local alcohol and drug treatment Providers;

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

(E) Hospice;

(F) Post Hospital Extended Care benefit, up to a 20-day stay in a Nursing Facility for non-Medicare DMAP 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;

(G) Cost sharing may apply to some covered services;

(b) QMB + OHP with limited drug Benefit Package coverage includes any service covered by Medicare, except that drugs or classes of drugs covered by Medicare Part D Prescription Drug are only covered by Medicare. Payment for services is the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible, except as limited in (E) below. This package also covers:

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

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

(C) Chemical dependency services provided through a local alcohol and drug treatment Provider;

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

(E) 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;

(F) DMAP will continue to coordinate benefits for drugs covered under Medicare Part B, subject to Medicare's benefit limitations and DMAP Provider rules;

(G) DMAP will cover 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 410

Division 121 for specific limitations). The drugs include but are not limited to:

(i) Benzodiazepines;

(ii) Over-the-Counter (OTC) drugs;

(iii) Barbiturates;

(c) OHP with limited drug Benefit Package for Fully Dual Eligible Clients includes any service covered by Medicare, except that drugs or classes of drugs covered by Medicare Part D Prescription Drug are only covered by Medicare. Payment for services is the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible, except as limited in (E) below. This package also covers:

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

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

(C) Chemical dependency services provided through a local alcohol and drug treatment Provider.

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

(E) 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;

(F) DMAP will continue to coordinate benefits for drugs covered under Medicare Part B, subject to Medicare's benefit limitations and DMAP Provider rules;

(G) DMAP will cover 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 410

Division 121 for specific limitations). The drugs include but are not limited to:

(i) Benzodiazepines;

(ii) Over-the-Counter (OTC) drugs;

(iii) Barbiturates;

(d) OHP Standard benefits adhere to the following provisions:

(A) OHP Standard coverage, subject to sections (B) and (C) of this section 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 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 DMAP 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) The following services have limited coverage for the OHP Standard benefit package (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) Selected Hospital services (OAR Chapter 410, Division 125);

(v) Other limitations as identified in individual DMAP program administrative rules.

(C) The following services are not covered under the OHP Standard Benefit Package. 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 DMAP program administrative rules.

(e) The QMB-Only Benefit Package provides only services that are also covered by Medicare:

(A) Payment for services is the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible, but no more than the Medicare allowable;

(B) Providers may bill QMB Clients for services that are not covered by Medicare. Providers may not bill QMB Clients for the deductible and coinsurance amounts due for services that are covered by Medicare.

(f) The Citizen/Alien-Waived Emergency Medical Assistance (CAWEM) Benefit Package provides limited services:

(A) Emergency medical services and labor and delivery services; CAWEM services are strictly defined by 42 CFR 440.255 (the definition does not apply a prudent layperson standard);

(B) A CAWEM Client is eligible for services only after 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;

(C) The following services are not covered for CAWEM Clients, even if they are seeking 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.

(4) DMAP covered health services are delivered through one of several means:

(a) Prepaid Health Plan (PHP):

(A) These Clients are enrolled in a PHP for their medical, dental and 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) Inpatient hospitalization services that are not the responsibility of a Physician Care Organization (PCO) are governed by the Hospital rules (OAR 410 Division 125);

(D) The name and phone number of the PHP appears on the Medical Care Identification.

(b) 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 PHP or assigned to a PCM;

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

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.

(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;

(c) Prescription drugs ordered through Division of Medical Assistance Program's (DMAP) Mail Order (a.k.a., Home-Delivery) Pharmacy program;

(d) Any service not listed in (10) below.

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

(a) Services provided to pregnant women;

(b) Children under age 19;

(c) Any Client receiving services under the Home and Community based waiver and Developmental Disability waiver, or is an inpatient in a hospital, Nursing Facility (NF), Intermediate Care Facility for the Mentally Retarded (ICF/MR);

(d) 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 P.L. 93-638.

(4) Clients enrolled in an DMAP contracted Prepaid Health Plan (PHP) will be exempt from co-payments for any services paid for by their plan(s).

(5) 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, nor does it prevent the Provider from attempting to collect any applicable co-payments from the Client; the amount is a legal debt, and is due and payable to the Provider of service.

(6) A Client must pay the co-payment at the time service is provided unless exempted (see (2), (3) and (4) above).

(7) The Provider should not deduct the co-payment amount from the usual and customary fee submitted on the claim. Except as provided in subsection (2) of this rule, DHS will deduct the amount of the co-payment from the amount paid to the Provider (whether or not Provider collects the co-payment from the Client). If the DMAP paid amount is less than the required co-payment, the co-payment amount will be equal to what DMAP would have paid, unless the Client or services is exempt according to exclusions listed in (2), (3) and (4) above.

(8) Unless specified otherwise in individual program rules, and to the extent permitted under 42 CFR 1001.951 – 1001.952, DMAP 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, DMAP will still deduct the co-payment amount from the Medicaid reimbursement made to the Provider.

(9) 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 Rule, 410-120-0000 et seq; any Oregon Health Plan Rule, OAR 410-141-0000 et seq; or individual DMAP program rule(s), that contain or refer to OHP Standard co-payment requirements.

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

(a) For the purposes of this rule, dental diagnostic services are considered oral examinations used to determine changes in the patient's health or dental status. Diagnostic visits include all routine cleanings, x-rays, laboratory services and tests associated with making a diagnosis and/or treatment. One co-payment assessed per Provider/per visit /per day unless otherwise specified. Co-payment applies regardless of location, i.e. Provider's office or Client's residence;

(b) Mental Health Service co-payments are defined as follows:

(A) Inpatient hospitalization- includes ancillary, facility and professional fees (DRG 424-432);

(B) Outpatient hospital- Electroconvulsive (ECT) treatment (Rev code 901) including facility, professional fees (90870-90871) and anesthesiology fees (00104);

(C) Initial assessment/evaluation by psychiatrist or psychiatric mental health nurse practitioners (90801);

(D) Medication Management by psychiatrist or psychiatric mental health nurse practitioner (90862);

(E) Consultation between psychiatrist/psychiatric mental health nurse practitioner and primary care physician (90887).

Table 120-1230-1

Statutory Authority: 409.050, 404.110 and 414.065: Department of Human Services functions; recipient of Federal Funds, Authority of Director, which authorize the Department of Human Services to establish rules for the administration of the Medical Assistance Programs and rules.
Other Authority: Title 19 of the Social Security Act, Title 42 Public Health of the Code of Federal Regulations, Oregon Administrative Rule (OAR) 410 Division 120, and 42USC1396a(bb) and 1396d (United States Code 42, Chapter 7, Subchapter 19). Public Law 93 -638. Section 1603 of Title 25. http://www.access.gpo.gov/uscode/uscmain.html

Statutes Implemented: 414.065

3-1-08

Table 120-1230-1

OHP Benefit Package **Client Co-payment Requirements**	**OHP Plus** **Effective 1/1/03**	**OHP Standard** **Effective 8/1/04**
Acupuncture services	$3	$0
Ambulatory Surgical Center	$3	$0
Ambulance Service (emergency)	$0	$0
Audiology services Hearing Aids	$3 $0	$0 Not covered
Chemical Dependency Services: Outpatient services Medication dosing/dispensing, case management Inpatient hospital detoxification	 $3 $0 $0	 $0 $0 $0
Chiropractic services	$3	Not covered
Dental Services: Diagnostic Restorative	 $0 $3	 $0 $0
DME and supplies	$0	$0

OHP Benefit Package **Client Co-payment Requirements**	**OHP Plus** **Effective 1/1/03**	**OHP Standard** **Effective 8/1/04**
Hospital:		
Inpatient Care	$0	$0
Outpatient Surgery	$3	$0
Emergency Room Services	$0	$0
Outpatient other	$3	$0
Non-emergent visit performed in the ER	$3	$0
Laboratory Tests	$0	$0
Mental Health Services:		
Outpatient services	$3	$0
Medication dosing/dispensing, case management	$0	$0
Inpatient hospitalization	$3	$0
OP Hospital for ECT	$3	$0
ECT professional fee	$3	$0
Initial assmt/eval by psychiatrist	$3	$0
Consult between professionals	$0	$0

OHP Benefit Package **Client Co-payment Requirements**	**OHP Plus** **Effective 1/1/03**	**OHP Standard** **Effective 8/1/04**
Naturopathic services	$3	$0
Vision services: Exams- medical Exams- for purpose of glasses Frames, contacts corrective devices	 $3 $3 $0	 $0 Not covered Not covered
Prescription Drugs: Non-preferred PDL or Generics in non-PDL classes costing > $10 Preferred PDL Generic or Generics in non-PDL classes costing < $10 Preferred PDL Brand All other Brands *STC 7&11 Drugs: All MCO enrollees are subject to the same co-pays for these drugs.	 $1 $0 $0 $3	 $0 $0 $0 $0

OHP Benefit Package Client Co-payment Requirements	OHP Plus Effective 1/1/03	OHP Standard Effective 8/1/04
Professional Visits for:		
Primary care, including urgent care: i.e. Physician, Physician Assistant or Nurse Practitioner	$3	$0
Specialty Care	$3	$0
Office Medical Procedure	$0	$0
Surgical Procedure	$0	$0
PT/OT/Speech	$3	Not covered
Home Visits For:		
Home Health	$3	Not covered
Private Duty Nursing	$3	Not covered
Enteral/Parenteral	$3	0
Podiatry services	$3	$0
Radiology:		
Diagnostic Procedures	$0	$0
Treatments	$0	$0

- Dental Services co-pays - refer to OAR 410-123-1085.
- PDL list – refer to OAR 410-121-0030-1

410-120-1260 Provider Enrollment

(1) This rule applies only to Providers seeking reimbursement from the Division of Medical Assistance Programs (DMAP), except as otherwise provided in OAR 410-120-1295 or OAR 407.

(2) Signing the Provider Agreement enclosed in the application package constitutes agreement by Performing and Billing Providers to comply with all applicable DMAP Provider rules and federal and state laws and regulations.

(3) The Department of Human Services (DHS) requires compliance with the National Provider Identification (NPI) requirements in 45 CFR Part 142. Providers that obtain an NPI should update their records with DMAP Provider Enrollment. Provider applicants that have been issued an NPI must include that NPI number with the DMAP Provider enrollment application;

(4) A Performing Provider is the Provider of a service or item. A Billing Provider is an individual, agent, business, corporation, clinic, group, institution, or other entity who, in connection with the submission of claims to the Department, receives or directs the payment (either in the name of the Performing Provider or the name of the Billing Provider) from DHS on behalf of a Performing Provider and has been delegated the authority to obligate or act on behalf of the Performing Provider

(a) A Billing Provider is responsible for identifying to DMAP and keeping current the identification of all Performing Providers for whom they bill, or receive or direct payments. This identification must include the Providers' names, DHS Provider numbers, NPIs, and either the Performing Provider's Social Security Number (SSN) or Employer Identification Number (EIN). The SSN or EIN of the Performing Provider cannot be the same as the Tax Identification Number of the Billing Provider. In order to facilitate timely claims processing and claims payment consistent with applicable privacy and security requirements, DHS requires Billing Providers to be enrolled consistent with the Provider enrollment process described in section (7) of this rule. A Performing Provider's use of a Billing

Provider that falls within the definition of a Billing Provider but that is not enrolled with DMAP will result in denial of claims or payment;

(b) If the Performing Provider uses electronic media to conduct transactions with the Department, or authorizes a Billing Provider to conduct such electronic transactions, the Performing Provider must comply with the DHS Electronic Data Interchange (EDI) rules, OAR 407-120-0100 through 407-120-0200. Enrollment as a Performing or Billing Provider is a necessary requirement for submitting electronic claims, but the Provider must also register as a Trading Partner and identify the EDI Submitter.

(5) To be enrolled and able to bill as a Provider, an individual or organization must meet applicable licensing and regulatory requirements set forth by federal and state statutes, regulations and rules, and must comply with all Oregon statutes and regulations for provision of Medicaid and SCHIP services. In addition, Providers of services within the State of Oregon must have a valid Oregon business license if such a license is a requirement of the state, federal, county or city government to operate a business or to provide services.

(6) An individual or organization that is currently subject to Sanction(s) by DMAP, another state's Medicaid program, or federal government is not eligible for enrollment (see OAR 410-120-1400, 407-120-0360 Provider Sanctions). In addition, individuals or organizations that apply for enrollment are subject to the following disclosure requirements:

(a) Before DMAP issues or renews a Provider number for Provider services, or at any time upon written request by DHS, the Provider must disclose to the Department the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or SCHIP program since the inception of those programs;

(b) A Medicaid Provider that is an entity other than an individual Practitioner or group of Practitioner's, must disclose certain information about ownership and control of the entity:

(A) The name and address of each person with an ownership or control interest in the Provider, or in any subcontractor in which the Provider has a direct or indirect ownership interest of 5 percent or more;

(B) Whether any of the persons so named is related to another as spouse, parent, child, sibling or other family members by marriage or otherwise; and

(C) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest;

(c) All Providers must agree to furnish to the Department or to the U.S. Department of Health and Human Services on request, information related to certain business transactions: A Provider must submit, within 35 days of the date of a request, full and complete information about the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request;

(d) DMAP may refuse to enter into or renew a Provider's enrollment agreement, or contract for Provider services, with a Provider if any person who has an ownership or control interest in the Provider, or who is an agent or managing employee of the Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid SCHIP or the Title XX services program;

(e) DMAP may refuse to enter into or may terminate a Provider enrollment agreement, or contract for Provider services, if it determines that the Provider did not fully and accurately make any disclosure required under this section (6) of this rule.

(7) Enrollment of Performing Providers. A DMAP assigned Performing Provider number will be issued to an individual or organization providing covered health care services or items upon:

(a) Completion of the application and submission of the required attachment, disclosure documents, and Provider Agreement.

(b) The signing of the Provider application by the Performing Provider or a person authorized by the Performing Provider to legally bind the organization or individual to compliance with these rules;

(c) Verification of licensing or certification. Loss of the appropriate licensure or certification will result in immediate disenrollment of the Provider and recovery of payments made subsequent to the loss of licensure or certification;

(d) Approval of the application package by DMAP or the DHS unit responsible for enrolling the Provider.

(8) Performing Providers may be enrolled retroactive to the date services were provided to a DMAP Client only if:

(a) The Provider was appropriately licensed, certified and otherwise met all DMAP requirements for Providers at the time services were provided; and

(b) Services were provided less than 12 months prior to the date the application for Provider status was received by DMAP as evidenced by the first date stamped on the paper claim(s) submitted with the application materials for those services, either manually or electronically;

(c) DMAP reserves the right to retroactively enroll the Provider prior to the 12 month period in (b) based upon extenuating circumstances outside the control of the Provider, consistent with federal Medicaid regulations, and with approval of the DMAP Provider Services Unit Manager.

(9) Issuance of a DHS assigned Provider number establishes enrollment of an individual or organization as a Provider for the specific category (ies) of services covered by the DMAP enrollment application. For example, a pharmacy Provider number applies to pharmacy services but not to Durable Medical Equipment, which requires a separate Provider application attachment and establishes a separate DHS assigned Provider number.

(10) Required Updates: A Provider is responsible for providing, and continuing to provide, to the Department accurate, complete and truthful information concerning their qualification for enrollment. An enrolled Provider must notify DMAP in writing of a material change in any status or condition that relates to their qualifications or eligibility to provide medical assistance services including but not limited to a change in any of the following information: address, business affiliation, licensure, certification, NPI, or Federal Tax Identification Number, or if the Provider's ownership or control information changes; or if the Provider or a person with an ownership or control interest, or an agent or managing employee of the Provider; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or SCHIP services program. The Provider must notify DMAP of changes in any of this information in writing within 30 calendar days of the change.

(a) Failure to notify DMAP of a change of Federal Tax Identification Number for entities or a Social Security Number or Employer Identification Number for individual Performing Providers may result in the imposition of a $50 fine;

(b) In addition to section(10) (a) of this rule, if DMAP notifies a Provider about an error in Federal Tax Identification Number including Social Security Numbers or Employer Identification Numbers for individual Performing Providers, the Provider must supply the appropriate valid Federal Tax Identification Number within 30 calendar days of the date of the DMAP notice. Failure to comply with this requirement may result in DMAP imposing a fine of $50 for each such notice. Federal Tax Identification Number requirements described in this rule refer to any such requirements established by the Internal Revenue Service;

(c) Changes in business affiliation, ownership, NPI and Federal Tax Identification Number, ownership and control information, or criminal convictions may require the submission of a new application;

(d) Claims submitted by, or payments made to, Providers who have not furnished the notification required by this rule or to a Provider that has failed to submit a new application as required by DMAP under this rule may be denied or recovered.

(11) Enrollment of Out-of-State Providers: Providers of services outside the state of Oregon will be enrolled as a Provider under section (7) of this rule if they comply with the requirements of section (7) and under the following conditions:

(a) The Provider is appropriately licensed or certified and meets standards and is enrolled within the Provider's state for participation in the state's Medicaid program. Disenrollment or sanction from the other state's Medicaid program, or exclusion from any other federal or state health care program is a basis for disenrollment, termination or suspension from participation as a Provider in Oregon’s medical assistance programs;

(b) Noncontiguous Out-of-State pharmacy Providers must be licensed by the Oregon Board of Pharmacy to provide pharmacy services in Oregon. In instances where clients are out of the state due to travel or other circumstances that prevent them from using a pharmacy licensed in Oregon, and prescriptions need to be filled, the pharmacy is required to be licensed in the State they are doing business where the client filled the prescription, and must be enrolled with DHS in order to submit claims. Out-of-state internet or mail order, except the Department mail order vendor, prescriptions are not eligible for reimbursement;

(c) The Provider bills only for services provided within the Provider's scope of licensure or certification;

(d) For noncontiguous Out-of-State Providers, the services provided must be authorized, in the manner required under these rules for Out-of-State Services (OAR 410-120-1180) or other applicable DHS rules:

(A) For a specific Oregon Medicaid Client who is temporarily outside Oregon or the contiguous area of Oregon; or

(B) For foster care or subsidized adoption children placed out of state; or

(C) The Provider is seeking Medicare deductible or coinsurance coverage for Oregon Qualified Medicare Beneficiaries (QMB) Clients.

(e) The services for which the Provider bills are covered services under the Oregon Health Plan (OHP);

(f) Facilities, including but not restricted to Hospitals, rehabilitative facilities, institutions for care of individuals with mental retardation, Psychiatric Hospitals, and residential care facilities, will be enrolled as Providers only if the facility is enrolled as a Medicaid Provider in the state in which the facility is located or is licensed as a facility Provider of services by the State of Oregon;

(g) Out-of-State Providers may provide contracted services per OAR 410-120-1880.

(12) Enrollment of Billing Providers:

(a) An individual or business entity that, in connection with the submission of claims to DMAP and receives or directs the payments from DMAP on the behalf of a professional Performing Provider (e.g., Physician, Physical Therapist, Speech Therapist) must be enrolled as a Billing Provider with DMAP and meet all applicable federal and state laws and regulations. A Billing Agent or Billing Service submitting claims or providing other business services on behalf of a Performing Provider but not receiving payment in the name of or on behalf of the Performing Provider does not meet the requirements for Billing Provider enrollment and is not eligible for enrollment as a Billing Provider;

(b) Billing Providers must complete an application for enrollment and submit all required documentation including a Provider Enrollment Agreement, consistent with the Provider enrollment process

described in subsection (7), to obtain a DHS assigned Provider Number. A DHS assigned Billing Provider number will be issued only to Billing Providers that have a contract with an enrolled Performing Provider to provide services in connection with the submission of claims and receive or direct payments on behalf of the Performing Provider, and that have met the standards for enrollment as a Billing Provider including one of the following as applicable:

(A) A corporate or business entity related to the Performing Provider under one of the relationships authorized by 42 CFR 447.10(g) may have the authority to submit the Performing Provider enrollment application and supporting documentation on behalf of the Performing Provider. Such entities with the authority to provide services in connection with the submission of claims and obtain or direct payment on behalf of the Performing Provider must enroll as a Billing Provider;

(B) Any other contracted Billing Agent or Billing Service (except as are described in section (12)(b) (A) of this rule) that has authority to provide services in connection with the submission claims and to receive or direct payment in the name of the Performing Provider pursuant to 42 CFR 447.10(f). Such entities with the authority to obtain or direct payment on behalf of the Performing Provider in connection with the submission of claims must enroll as a Billing Provider;

(C) These Billing Provider enrollment requirements do not apply to the staff directly employed by an enrolled Performing Provider, rather than pursuant to a contractual arrangement. Nothing in this rule is meant to prevent an enrolled Performing Provider from submitting his or her own claims and receiving payment in his or her own name. Notwithstanding this provision, if the Performing Provider is conducting electronic transactions, the DHS EDI rules will apply, consistent with section (4) of this rule.

(c) A Billing Provider must maintain, and make available to DMAP, upon request, records indicating the Billing Provider's relationship with the Provider of service;

(d) Prior to submission of any claims or receipt or direction of any payment from DMAP, the Billing Provider must obtain signed confirmation from the Performing Provider that the Billing Provider has been authorized by the Performing Provider to submit claims or receive or direct payment on behalf of the Performing Provider. This authorization, and any limitations or termination of such authorization, must be maintained in the Billing Provider's files for at least five years, following the submission of claims or receipt or direction of funds from DMAP;

(e) The Billing Provider fee must not be based on a percentage of the amount billed or collected or whether or not they collect the subject's payment (42 CFR 447.10(f)).

(f) If the Billing Provider is authorized to use electronic media to conduct transactions on behalf of the Performing Provider, the Performing Provider must register with the Department as a Trading Partner and authorize the Billing Provider to act as an EDI Submitter, as required in the Electronic Data Interchange (EDI) rules, OAR 407-120-0100 through 407-120-0200. Enrollment as a Billing Provider does not provide that authority. If the Performing Provider uses electronic media to conduct transactions, and authorizes a Billing Agent or Billing Service that is not authorized to receive reimbursement or otherwise obligate the Performing Provider, the Billing Agent or Billing Service does not meet the requirements of a Billing Provider. The Performing Provider and Billing Agent or Billing Service must comply with the DHS EDI rules, OAR 407-120-0100 through 407-120-0200.;

(g) Out-of-state Billing Providers may need to register with the Secretary of State and the Department of Revenue to transact business in Oregon pursuant to 407-120-0320(15)(f).

(h) All Billing Providers are required to notify DMAP, at the time of enrollment or within 30 days of any change, of the names of all Performing Providers and their DHS Provider Number, NPI number and the Social Security Number or Employer Identification Numbers of the Performing Providers. The Performing Provider’s SSN or EIN is required pursuant to 42 CFR 433.37, including federal tax laws at 26

USC 6041. SSN's and EIN's provided pursuant to this authority are used for the administration of federal, state, and local tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities. In addition, this information is necessary for DHS to timely process and pay claims.

(13) Utilization of Locum Tenens:

(a) For purposes of this rule, a locum tenens means a substitute Physician retained to take over another Physician's professional practice while he or she is absent (i.e., absentee Physician) for reasons such as illness, vacation, continuing medical education, pregnancy, etc.

(b) Locum tenens are not required to enroll with DMAP; however, DMAP may enroll locum tenens Providers at the discretion of the Provider Services Manager if that Provider submits a complete enrollment application, especially in areas of the State underserved with medical Providers. In no instance may an enrolled absentee Physician utilize a substitute Physician who is, at that time, excluded from participation in or under Sanction by Medicaid or federally funded or federally assisted health programs.

(c) The absentee Physician must be an enrolled DMAP Provider and must bill with their individual DMAP assigned Provider number and receive payment for covered services provided by the locum tenens Physician. Services provided by the locum tenens must be billed with a modifier Q6:

(A) In entering the Q6 modifier, the absentee Physician is certifying that the services are provided by a substitute Physician identified in a record of the absentee Physician that is available for inspection, and are services for which the absentee Physician is authorized to submit a claim;

(B) A Physician or other person who falsely certifies that the requirements of this section are met may be subject to possible civil

and criminal penalties for fraud, and the enrolled Provider's right to receive payment or to submit claims may be revoked.

(14) Reciprocal Billing Arrangements:

(a) For purposes of this rule, reciprocal billing arrangements are similar in nature to a locum tenens in that a substitute Physician is retained to take over another Physician's professional practice on an occasional basis if the regular Physician is unavailable (absentee Physician);

(b) Providers with reciprocal billing arrangements are not required to enroll with DMAP; however, in no instance may an enrolled absentee Physician utilize a substitute Physician who is, at that time, excluded from participation in or under Sanction by Medicaid or federally funded or federally assisted health programs;

(c) The absentee Physician must be an enrolled DMAP Provider and must bill with his or her individual DMAP assigned Provider number and receive payment for covered services provided by the substitute Physician. The absentee Physician identifies the services provided by the substitute Physician by using modifier Q5:

(A) In entering the Q5 modifier, the absentee Physician is certifying that the services are provided by a substitute Physician identified in a record of the absentee Physician that is available for inspection, and are services for which the absentee Physician is authorized to submit a claim.

(B) A Physician or other person who falsely certifies that the requirements of this section are met may be subject to possible civil and criminal penalties for fraud, and the enrolled Provider's right to receive payment or to submit claims may be revoked.

(d) These requirements do not apply to substitute arrangements among Physicians in the same medical practice when claims are submitted in the name of the Billing Provider or group name. Nothing in this rules prohibits Physicians sharing call responsibilities from opting out of the reciprocal billing (substitute Provider)

arrangement described in this rule and submitting their own claims for services provided, as long as all such physicians are themselves enrolled Performing Providers and as long as duplicate claims for services are not submitted.

(15) Provider Termination:

(a) The Provider may terminate enrollment at any time. The request must be in writing, and signed by the Provider. The notice shall specify the DMAP assigned Provider number to be Terminated and the effective date of Termination. Termination of the Provider enrollment does not terminate any obligations of the Provider for dates of services during which the enrollment was in effect;

(b) DMAP Provider Terminations or Suspensions may be for, but are not limited to the following reasons:

(A) Breaches of Provider agreement;

(B) Failure to comply with the statutes, regulations and policies of DHS, Federal or State regulations that are applicable to the Provider.

(C) When no claims have been submitted in an 18-month period. The Provider must reapply for enrollment.

(16) When a Provider fails to meet one or more of the requirements governing a Provider's participation in Oregon’s medical assistance programs, the Provider's DMAP assigned Provider number may be immediately suspended. The Provider is entitled to a contested case hearing as outlined in 410-120-1600 through 410-120-1840 to determine whether the Provider's DMAP assigned number will be revoked.

(17) The provision of health care services or items to DMAP Clients is a voluntary action on the part of the Provider. Providers are not required to serve all DMAP Clients seeking service.

(18) In the event of bankruptcy proceedings, the Provider must immediately notify the DMAP Administrator in writing.

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050, 409.110
Stats. Implemented: ORS 414.019, 414.025, 414.065,

12-01-08

410-120-1280 Billing

(1) A Provider enrolled with the Division of Medical Assistance Programs (DMAP) must bill using the DHS assigned provider number, in addition to the National Provider Identification (NPI) number, if the NPI is available, pursuant to 407-120-0320.

(2) For Medicaid covered services the Provider must not bill DMAP more than the Provider's Usual Charge (see definitions) or the reimbursement specified in the applicable Provider rules:

(a) A Provider enrolled with DHS or providing services to a Client in a managed care plan under the Oregon Health Plan (OHP) must not seek payment for any services covered by Medicaid fee-for-service or through contracted managed care plans, except any coinsurance, co-payments, and deductibles expressly authorized by the General Rules, OHP Rules or individual Provider rules:

(A) An DMAP 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 DMAP rules in OAR 410 Division 120, OAR 410 Division 141, or any other individual Provider 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 DMAP, 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 DMAP benefits retroactively but did not meet other established criteria described in these General Rules and the appropriate Provider 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 DMAP 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 DMAP;

(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 DMAP General Rules (410-120-1230) and individual Provider 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 DMAP 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 DMAP, and that the Client cannot be billed for an amount greater than the maximum DMAP 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 DMAP 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 DMAP 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 DMAP 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 Provider 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 DMAP.

(4) All claims must be billed on the appropriate form as described in the individual Provider rules or submitted electronically in a manner authorized by the Department of Human Services (DHS) Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et. seq.

(5) Upon submission of a claim to DMAP for payment, the Provider agrees that it has complied with all DMAP Provider 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 DMAP. 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 DMAP individual provider 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 DMAP 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) DMAP 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, DMAP will update its Provider rules and tables to conform to national codes. In the event of an alleged variation between an DMAP-listed code and a national code, DMAP will apply the national code in effect on the date of request or date of service and the Provider, and the DMAP-listed code may be used for the limited purpose of describing DMAP'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 DMAP coverage, or a covered service.

(d) DMAP 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 DMAP 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 DMAP Provider 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 DMAP Provider 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 Provider rules. Hospitals must follow national coding guidelines:

(a) When there is no appropriate descriptive procedure code to bill DMAP, 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 DMAP using that code rather than itemizing the services under multiple codes. Providers must not "unbundled" services in order to increase DMAP payment.

(13) No Provider or its contracted agency (including Billing Providers) shall submit or cause to be submitted to DMAP:

(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 DMAP.

(15) A Provider who, after having been previously warned in writing by DMAP 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 DMAP for up to triple the amount of the DMAP 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 DMAP 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 DMAP the Provider must:

(A) Bill the TPR; and

(B) Except for pharmacy claims billed through DMAP'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 DMAP, 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 DMAP. The Provider may not both place a lien against a settlement and bill DMAP. The Provider may withdraw the lien and bill DMAP within 12 months of the date of service. If the Provider bills DMAP the Provider must accept payment made by DMAP as payment in full.

(F) The Provider must not return the payment made by DMAP 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 DMAP. Otherwise, DMAP will process the claim and, if applicable, will pay the DMAP allowable rate for these services and seek reimbursement from the liable third party insurance plan;

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

(e) The Provider may bill DMAP 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 DMAP, 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 DMAP Client shall:

(i) Submit an Individual Adjustment Request after submitting a claim to DMAP 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 DMAP for the specific service or item, the Provider shall make direct payment of the amount of the third party payment to DMAP. When the Provider chooses to directly repay the amount of the third party payment to DMAP, 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 DMAP payment.

(g) DMAP reserves the right to make a claim against any third party payer after making payment to the Provider of service. DMAP 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 DMAP in accordance with (15) of this rule;

(h) For services rendered to a Medicare and Medicaid dual eligible Client, DMAP 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 DMAP. Medicare denial on the basis of failure to submit a timely appeal may result in DMAP reducing from the amount of the claim any amount DMAP determines could have been paid by Medicare.

(17) Full Use of Alternate Resources:

(a) DMAP 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.

Table 120-1280 -TPR Codes.

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050, 409.110

Stats. Implemented: ORS 414.019, 414.025, 414.065, 414.085

12-01-08

Table 120-1280 Third Party Resource (TPR) Explanation Codes

Use in Field “9” on the CMS-1500

Single Insurance Coverage

Use a single insurance code when the client has only one insurance policy in addition to DMAP coverage

UD Service Under Deductible

NC Service Not Covered by Insurance Policy

PN Patient Not Covered by Insurance Policy

IC Insurance Coverage Cancelled/Terminated

IL Insurance Lapsed or Not in Effect on Date of Service

IP Insurance Payment Went to Policyholder

PP Insurance Payment Went to Patient

NA Service Not Authorized or Prior Authorized by Insurance

NE Service Not Considered Emergency by Insurance

NP Service Not Provided by Primary Care Provider/Facility

MB Maximum Benefits Used for Diagnosis/Condition

RI Requested Information Not Received by Insurance from Client

RP Requested Information Not Received by Insurance from Policy holder

MV Motor Vehicle Accident Fund Maximum Benefits Exhausted

AP Insurance mandated under administrative/court order through an absent parent not paid within 30 days

OT Other (if above codes do not apply, include detailed information of why no TPR payment was made)

Multiple Insurance Coverage

Use a multiple insurance code when the client has more than one insurance policy in addition to DMAP coverage

MP Primary Insurance Paid-Secondary Paid

SU Primary Insurance Paid - Secondary Under Deductible

MU Primary and Secondary Under Deductible

PU Primary Insurance Under Deductible - Secondary Paid

SS Primary Insurance Paid - Secondary Service Not Covered

SC Primary Insurance Paid - Secondary Patient Not Covered

ST Primary Insurance Paid - Secondary Insurance Cancelled/Terminated

SL Primary Paid - Secondary Lapsed or Not in Effect

SP Primary Paid - Secondary Payment Went to Patient

SH Primary Paid - Secondary Payment Went to Policyholder

SA Primary Paid - Secondary Denied - Service Not Authorized or Prior Authorized

SE Primary Paid - Secondary Denied - Service Not Considered Emergency

SF Primary Paid - Secondary Denied - Service Not Provided by Primary Care Provider/Facility

SM Primary Paid - Secondary Denied - Maximum Benefits Used for Diagnosis/Condition

SI Primary Paid - Secondary Denied - Requested Information Not Received from Policyholder

SR Primary Paid - Secondary Denied - Requested Information Not Received from Patient

MC Service Not Covered by Primary or Secondary Insurance

MO Other (if above codes do not apply, include detailed information of why no TPR payment was made)

410-120-1295 Non-Participating Provider

(1) For purposes of this rule, a Provider enrolled with the Division of Medical Assistance Programs (DMAP) that does not have a contract with an DMAP-contracted Prepaid Health Plan (PHP) is referred to as a Non-Participating Provider.

(2) For covered services that are subject to reimbursement from the PHP, a Non-Participating Provider, other than a hospital governed by (3) or (4) below, must accept from the DMAP-contracted PHP, as payment in full, the amount that the provider would be paid from DMAP if the client was fee-for-service (FFS).

(3) For covered services provided on and after January 1, 2008, the DMAP-contracted 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) The FCHP will 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 capitation rates paid to the FCHP for the contract period (ORS 414.727);

(b) The FCHP will reimburse inpatient and outpatient services in all other non-participating hospitals, not designated as a rural access or Type A and Type B Hospital, will be based upon 80 percent of the Medicare rate. Emergency services must be consistent with 42 USC 1396u-2(b)(2)(D),

(4) For covered services provided through and including December 31, 2007, the DMAP-contracted 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) The FCHP will 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 capitation rates paid to the FCHP for the contract period (ORS 414.727);

(b) The FCHP will reimburse inpatient and outpatient services in all other non-participating hospitals, not designated as a rural access or Type A and Type B Hospital according to the following method:

(A) Inpatient service rates are based upon the capitation rates developed for the budget period, at the level of the statewide average unit cost, multiplied by the geographic factor, the payment discount factor and an adjustment factor of 0.925;

(Bi) Outpatient service rates are based upon the capitation rates developed for the budget period, at the level of charges, multiplied by the statewide average cost to charge ratio, the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(5) The geographic factor, and the statewide average unit costs for inpatient service rates for subsection (4)(b)(A) and for outpatient service rates for subsection (3)(b)(Bi), are calculated by the Department's contracted actuarial firm. The FCHP Non-Contracted DRG Hospital Reimbursement Rates are on the Department's Web site at: www.dhs.state.or.us/policy/healthplan/guides/hospital/main.html, archived data is available on request from DMAP. Each document shows rates for a specific date range. The document dated:

(a) October 1, 2005, is effective for dates of service October 1, 2005 through December 31, 2005; (corrected December 23, 2005);

(b) January 1, 2006, is effective for dates of service January 1, 2006 through December 31, 2006 (corrected December 23, 2005);

(c) January 1, 2007, is effective for dates of service January 1, 2007 through December 31, 2007.

(6) A non-participating hospital must notify the FCHP within 2 business days of an FCHP patient admission when the FCHP is the primary payer. Failure to notify does not, in and of itself, result in denial for payment. The 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 FCHP contract and DMAP Administrative Rules.

(6) After notification from the non-participating hospital, the FCHP may:

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

(b) Perform concurrent review; and/or

(c) Perform case management activities.

(7) In the event of a disagreement between the 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 409.050, 409.010, 409.110 and 414.065

Stats. Implemented: ORS 414.743

1-1-08

410-120-1300 Timely Submission of Claims

(1) All claims for services must be submitted within 12 months of the date of service. The date of service for an Inpatient Hospital stay is considered the date of discharge.

(2) A claim that was submitted within 12 months of the date of service, but that was denied, may be resubmitted within 18 months of the date of service. These claims must be submitted to the Division of Medical Assistance Programs (DMAP) at the address listed in the Provider Contacts document. The Provider must present documentation acceptable to DMAP verifying the claim was originally submitted within 12 months of the date of service, unless otherwise stated in individual Provider rules. Acceptable documentation is:

(a) A remittance advice from DMAP that shows the claim was submitted before the claim was one year old;

(b) A copy of a billing record or ledger showing dates of submission to DMAP.

(3) Exceptions to the 12-month requirement that may be submitted to DMAP are as follows:

(a) When DMAP or the Client's branch office has made an error that caused the Provider not to be able to bill within 12 months of the date of service. DMAP must confirm the error;

(b) When a court or an Administrative Law Judge has ordered DMAP to make payment;

(c) When the Department determines a Client is retroactively eligible for DMAP medical coverage and more than 12 months have passed between the date of service and the determination of the Client's eligibility.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065 1-1-07

410-120-1320 Authorization of Payment

(1) Some of the services or items covered by the Division of Medical Assistance Programs (DMAP) require authorization before payment will be made. Some services require authorization before the service can be provided. See the appropriate Provider rules for information on services requiring authorization and the process to be followed to obtain authorization. Services (except Medical Transportation) for Clients identified by DMAP as "medically fragile children," shall be authorized by the Department of Human Services (DHS) Medically Fragile Children's Unit.

(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 Provider rules.

(3) The authorizing agency 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 Department and its authorizing agencies are not required to authorize services or to 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) Payment made for services described in subsections (a) through (g) of this rule will be recovered (see also Basis for Mandatory Sanctions and Basis for Discretionary Sanctions).

(6) Retroactive Eligibility:

(a) In those instances when Clients are made retroactively eligible, authorization for payment may be given if:

(A) The Client was eligible 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 by the appropriate DHS branch or DMAP within 90 days of the date of service;

(b) Services provided when a Title XIX Client is retroactively disenrolled from a Prepaid Health Plan (PHP) or services provided after the Client was disenrolled from a PHP may be authorized if: (A) The Client was eligible on the date of service;

(B) The services provided meet all other criteria and Oregon Administrative Rules;

(C) The request for authorization is received by the appropriate DHS branch or DMAP 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) Payment Authorization for Clients with other insurance or for Medicare beneficiaries:

(a) When Medicare is the primary payer for a service, no Payment Authorization from DMAP is required, unless specified in the appropriate program Provider rules;

(b) For Clients who have private insurance or other Third Party Resources (TPRs), such as Blue Cross, CHAMPUS, etc., DMAP requires Payment Authorization as specified above and in the appropriate Provider rules when the other insurer or resource does not cover the service or when the other insurer reimburses less than the DMAP rate;

(c) For Clients in a Medicare's Social Health Maintenance Organization (SHMO), the SHMO requires Payment Authorization for some services. DMAP requires Payment Authorization for services which are covered by DMAP but which are not covered under the SHMO as specified above and in the appropriate Provider rules.

Stat. Auth.: ORS 409.050, 409.010, 409.110 and 414.065
Stats. Implemented: ORS 414.065 1-1-08

410-120-1340 Payment

(1) The Division of Medical Assistance Programs (DMAP) will make payment only to the enrolled Provider 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 electronic transactions will be submitted, Billing Agents and Billing Services must register and comply with Department of Human Services (DHS) Electronic Data Interchange (EDI) rules, OAR 407-120-0100 through 407-120-0200. DMAP may require that payment for services be made only after review by DMAP.

(2) DMAP or the Department of Human Services (DHS) office that is administering the program under which the billed services or items are provided sets Fee-for-Service (FFS) payment rates.

(3) All FFS payment rates are the rates in effect on the date of service that are the lesser of the amount billed, the DMAP maximum allowable amount or the reimbursement specified in the individual program Provider rules:

(a) Amount billed may not exceed the Provider's Usual Charge (see definitions);

(b) DMAP's maximum allowable rate setting process uses the following methodology. The rates are updated periodically and posted on the DMAP web site at http://www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml:

(A) For all CPT/HCPCS codes assigned a Relative Value Unit (RVU) weight and reflecting services not typically performed in a facility, DMAP will convert to the 2008 Transitional Non-Facility Total RVU weights published in the Federal Register, Vol. 73, January 15, 2008, to be effective for dates of services beginning January 1, 2009. For CPT/HCPCS codes for professional services typically performed in a facility, the Transitional Facility RVU weight Totals will be adopted:

(i) The conversion factor for labor and delivery (59400-59622) is $41.61;

(ii) CPT codes 92340-92342 and 92352-92353 remain at a flat rate of $26.81;

(iii) All remaining RVU weight based CPT/HCPCS codes have a conversion factor of $27.82;

(B) Surgical assist reimburses at 20% of the surgical rate;

(C) The base rate for anesthesia services 00100-01996 is $24.19 and is based on per unit of service;

(D) Clinical lab codes are priced based upon the Centers for Medicare and Medicaid Service (CMS) mandates. Other Non-RVU weight based Lab vary by code are generally between 62% to 97% of Medicare's rates;

(E) All approved Ambulatory Surgical Center (ASC) procedures are reimbursed at 80% of Medicare's fee schedule;

(F) 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 will be based upon Average Wholesale Price (AWP). Pricing information for AWP is provided by First Data Bank. These rates may change periodically based on drug costs;

(G) All procedures used for vision materials and supplies are based on contracted rates which include acquisition cost plus shipping and handling;

(c) Individual Provider rules may specify reimbursement rates for particular services or items.

(4) DMAP reimburses Inpatient Hospital service under the DRG methodology, unless specified otherwise in the DMAP Hospital services administrative rules (chapter 410 division 125). Reimbursement for

services, including claims paid at DRG rates, will not exceed any Upper Limits established by federal regulation.

(5) DMAP reimburses all out-of-state Hospital services at Oregon DRG or fee-for-service rates as published in the Hospital Services rules (OAR 410 Division 125) unless the Hospital has a contract or Service Agreement with DMAP to provide highly specialized services.

(6) Payment rates for in-home services provided through DHS Seniors and People with Disabilities Division (SPD) will not be greater than the current DMAP rate for Nursing Facility payment.

(7) DHS 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 SPD for out-of-state Nursing Facilities.

(8) DMAP will 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.

(9) DMAP will 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 administrative rules (chapter 410 division 121) and Home Enteral/Parenteral Nutrition and IV Services 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 131 and 129);

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

(d) Influenza immunization serum as described in the Pharmaceutical Services administrative rules, (chapter410 division 121);

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

(f) Medical services provided by Physician or other Provider of medical services, such as radiology and Laboratory, as outlined in the Medical-Surgical Services Provider rules, (chapter 410 division 130);

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment and Medical Supplies administrative rules, (chapter 410 division 122).

(10) DMAP reimburses Hospice services on a per diem basis dependent upon the level of care being provided. A separate payment will not be made for services included in the core package of services as outlined in OAR 410 Division 142.

(11) Payment for DMAP Clients with Medicare and full Medicaid:

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

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

(12) For Clients with Third-Party Resources (TPR), DMAP pays the DMAP allowed rate less the TPR payment but not to exceed the billed amount.

(13) DMAP payments, including contracted Prepaid Health Plan (PHP) payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For DMAP 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 the DMAP 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.

(14) Payment by DMAP does not limit DHS or any state or federal oversight entity from reviewing or auditing a claim before or after the payment. 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 409.010, 409.025, 409.040, 409.050, 409.110

Stats. Implemented: ORS 414.019, 414.025, 414.033, 414.065, 414.095, 414.705, 414.727, 414.728, 414.742, 414.743 1-01-09

410-120-1350 Buying-Up

(1) Providers are not permitted to bill and accept payment from the Division of Medical Assistance Programs (DMAP) or a managed care plan for a covered service:

(a) When a Non-Covered Service has been provided; and

(b) Additional payment is sought or accepted from the DMAP Client;

(2) Examples include, but are not limited to, charging the Client an additional payment to obtain a gold crown (non covered) instead of the stainless steel crown (covered) or charging an additional Client payment to obtain eyeglass frames not on the DMAP or managed care plan contract.

(3) If a Client wants to purchase a Non-Covered Service or item, the Client must be responsible for full payment. DMAP or managed care plan payment for a covered service cannot be credited toward the Non-Covered Service.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

410-120-1360 Requirements for Financial, Clinical and Other Records

The Department of Human Services (DHS) is responsible for analyzing and monitoring the operation of the Division of Medical Assistance Programs (DMAP) and for auditing and verifying the accuracy and appropriateness of payment, utilization of services, medical necessity, medical appropriateness, the quality of care, and access to care. The Provider or the Provider's designated billing service or other entity responsible for the maintenance of financial, clinical, and other records, shall:

(1) Develop and maintain adequate financial and clinical records and other documentation which supports the specific care, items, or services for which payment has been requested. Payment will be made only for services that are adequately documented. Documentation must be completed before the service is billed to DMAP:

(a) All records must document the specific service provided, the number of services or items comprising the service provided, the extent of the service provided, the dates on which the service was provided, and the individual who provided the service. Patient account and financial records must also include documentation of charges, identify other payment resources pursued, indicate the date and amount of all debit or credit billing actions, and support the appropriateness of the amount billed and paid. For cost reimbursed services, the Provider is required to maintain adequate records to thoroughly explain how the amounts reported on the cost statement were determined. The records must be accurate and in sufficient detail to substantiate the data reported;

(b) Clinical records, including records of all therapeutic services, must document the Client's diagnosis and the medical need for the service. The Client's record must be annotated each time a service is provided and signed or initialed by the individual who provided the service or must clearly indicate the individual(s) who provided the service. Information contained in the record must be appropriate in quality and quantity to meet the professional standards applicable to the Provider or practitioner and any additional standards for documentation found in this rule, the individual Provider rules and any pertinent contracts.

(c) Have policies and procedures to ensure the maintenance of the confidentiality of medical record information. These procedures ensure the Provider may release such information in accordance with federal and state statutes, ORS 179.505 through 179.507, 411.320, 433.045, 42 CFR part 2, 42 CFR subpart F, 45 CFR 205.50, including ORS 433.045(3) with respect to HIV test information.

(2) Retain clinical records for seven years and financial and other records described in subsections (a) and (b) of this rule for at least five years from the date(s) of service.

(3) Upon written request from DHS, the Medicaid Fraud Unit, Oregon Secretary of State, or the Department of Health and Human Services (DHHS), or their authorized representatives, furnish requested documentation immediately or within the time-frame specified in the written request. Copies of the documents may be furnished unless the originals are requested. At their discretion, official representatives of DHS, Medicaid Fraud Unit, or DHHS, may review and copy the original documentation in the Provider's place of business. Upon the written request of the Provider, the Program or the Unit may, at their sole discretion, modify or extend the time for provision of such records if, in the opinion of the Program or Unit good cause for such extension is shown. Factors used in determining whether good cause exists include:

(a) Whether the written request was made in advance of the deadline for production;

(b) If the written request is made after the deadline for production, the amount of time elapsed since that deadline;

(c) The efforts already made to comply with the request;

(d) The reasons the deadline cannot be met;

(e) The degree of control that the Provider had over its ability to produce the records prior to the deadline;

(f) Other extenuating factors.

(4) Access to records, inclusive of medical charts and financial records does not require authorization or release from the Client if the purpose of such access is:

(a) To perform billing review activities; or

(b) To perform utilization review activities; or

(c) To review quality, quantity, medical appropriateness of care, items, and services provided; or

(d) To facilitate payment authorization and related services; or

(e) To investigate a Client's fair hearing request; or

(f) To facilitate investigation by the Medicaid Fraud Unit or DHHS; or

(g) Where review of records is necessary to the operation of the program.

(5) Failure to comply with requests for documents and within the specified time-frames means that the records subject to the request may be deemed by DHS not to exist for purposes of verifying appropriateness of payment, medical appropriateness, the quality of care, and the access to care in an audit or overpayment determination, and accordingly subjects the Provider to possible denial or recovery of payments made by DMAP or to sanctions.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-120-1380 Compliance with Federal and State Statutes

(1) When a Provider submits a claim for medical services or supplies provided to an Division of Medical Assistance Programs (DMAP) Client, DMAP will deem the submission as a representation by the medical Provider to the Medical Assistance Program of the medical Provider's compliance with the applicable sections of the federal and state statutes referenced in this rule:

(a) 45 CFR Part 84 which implements Title V, Section 504 of the Rehabilitation Act of 1973;

(b) 42 CFR Part 493 Laboratory Requirements and ORS 438 (Clinical Laboratories).

(c) Unless exempt under 45CFR Part 87 for Faith-Based Organizations (Federal Register, July 16, 2004, Volume 69, #136), or other federal provisions, the Provider must comply and, as indicated, cause all sub-contractors to comply with the following federal requirements to the extent that they are applicable to the goods and services governed by these rules. For purposes of these rules, all references to federal and state laws are references to federal and state laws as they may be amended from time to time:

(A) The Provider must comply and cause all subcontractors to comply with all federal laws, regulations, executive orders applicable to the goods and services provided under these rules. Without limiting the generality of the foregoing, the Provider expressly agrees to comply and cause all subcontractors to comply with the following laws, regulations and executive orders to the extent they are applicable to the goods and services provided under these rules:

(i) Title VI and VII of the Civil Rights Act of 1964, as amended;

(ii) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended;

(iii) The Americans with Disabilities Act of 1990, as amended;

(iv) Executive Order 11246, as amended;

(v) The Health Insurance Portability and Accountability Act of 1996;

(vi) The Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended;

(vii) The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (viii) all regulations and administrative rules established pursuant to the foregoing laws;

(viii) All other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations;

(ix) All federal law governing operation of Community Mental Health Programs, including without limitation, all federal laws requiring reporting of Client abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the goods and services governed by these rules and required by law to be so incorporated. No federal funds may be used to provide services in violation of 42 USC 14402.

(B) Any Provider that receives or makes annual payments under the Title XIX State Plan of at least $5,000,000, as a condition of receiving such payments, shall:

(i) Establish written policies for all employees of the entity (including management), and of any contractor, subcontractor, or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any Oregon State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblowing protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

(ii) Include as part of written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse; and

(iii) Include in any employee handbook for the entity, a specific discussion of the laws described in (i), the rights of the employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(B) If the goods and services governed under these rules exceed $10,000, the Provider must comply and cause all subcontractors to comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in DHS of Labor regulations (41 CFR Part 60);

(C) If the goods and services governed under these rules exceed $100,000, the Provider must comply and cause all subcontractors to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act—33 U.S.C. 1251 to 1387), specifically including, but not limited to, Section 508 (33 U.S.C. 1368). Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 32), which prohibit the use under non-exempt Federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations must be reported to the Department of Human Services (DHS), the federal Department of Health and Human Services (DHHS) and the appropriate Regional Office of the Environmental Protection Agency. The Provider must include and cause all subcontractors to include in all contracts with subcontractors receiving more than $100,000, language requiring the subcontractor to comply with the federal laws identified in this section;

(D) The Provider must comply and cause all subcontractors to comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act, 42 U.S.C. 6201 et seq. (Pub. L. 94-163);

(E) The Provider certifies, to the best of the Provider's knowledge and belief, that:

(i) No federal appropriated funds have been paid or will be paid, by or on behalf of the Provider, to any person for influencing or attempting to

influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement;

(ii) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the Provider must complete and submit Standard Form LLL, “Disclosure Form to Report Lobbying” in accordance with its instructions;

(iii) The Provider must require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients and subcontractors must certify and disclose accordingly;

(iv) This certification is a material representation of fact upon which reliance was placed when this Provider agreement was made or entered into. Submission of this certification is a prerequisite for making or entering into this Provider agreement imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification will be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

(F) If the goods and services funded in whole or in part with financial assistance provided under these rules are covered by the Health Insurance Portability and Accountability Act or the federal regulations implementing the Act (collectively referred to as HIPAA), the Provider agrees to deliver the goods and services in compliance with HIPAA. Without limiting the generality of the foregoing, goods and services funded in whole or in part with financial assistance provided under these rules are covered by HIPAA. The Provider must comply and cause all subcontractors to comply with the following:

(i) Individually Identifiable Health Information about specific individuals is confidential. Individually Identifiable Health Information relating to specific individuals may be exchanged between the Provider and DHS for purposes directly related to the provision to Clients of services that are funded in whole or in part under these rules. However, the Provider must not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate DHS Privacy Rules, OAR 410-014-0000 *et. seq.*, or DHS Notice of Privacy Practices, if done by DHS. A copy of the most recent DHS Notice of Privacy Practices is posted on the DHS Web site or may be obtained from DHS;

(ii) If the Provider intends to engage in Electronic Data Interchange (EDI) transactions with DHS in connection with claims or encounter data, eligibility or enrollment information, authorizations or other electronic transactions, the Provider must execute an EDI Trading Partner Agreement with DHS and must comply with the DHS EDI rules;

(iii) If a Provider reasonably believes that the Provider's or the DHS' data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, the Provider must promptly consult the DHS Privacy Officer. The Provider or DHS may initiate a request to test HIPAA transactions, subject to available resources and the DHS testing schedule.

(G) The Provider must comply and cause all subcontractors to comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 USC 6901 et. seq.). Section 6002 of that Act (codified at 42 USC 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Parts 247;

(H) The Provider must comply and, if applicable, cause a subcontractor to comply, with the applicable audit requirements and responsibilities set forth in the Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations;"

(I) The Provider must not permit any person or entity to be a subcontractor if the person or entity is listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12,549 and No. 12,689, "Debarment and Suspension". (See 45 CFR part 76). This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and Providers and subcontractors declared ineligible under statutory authority other than Executive Order No. 12549. Subcontractors with awards that exceed the simplified acquisition threshold must provide the required certification regarding their exclusion status and that of their principals prior to award;

(J) The Provider must comply and cause all subcontractors to comply with the following provisions to maintain a drug-free workplace:

(i) The Provider certifies that it will provide a drug-free workplace by publishing a statement notifying its employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, except as may be present in lawfully prescribed or over-the-counter medications, is prohibited in the Provider's workplace or while providing services to DHS Clients. The Provider's notice must specify the actions that will be taken by the Provider against its employees for violation of such prohibitions;

(ii) Establish a drug-free awareness program to inform its employees about the dangers of drug abuse in the workplace, the Provider's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations;

(iii) Provide each employee to be engaged in the performance of services under these rules a copy of the statement mentioned in paragraph (J)(i) above;

(iv) Notify each employee in the statement required by paragraph (J)(i) that, as a condition of employment to provide services under these rules, the employee will abide by the terms of the statement and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction;

(v) Notify DHS within ten (10) days after receiving notice under subparagraph (J)(iv) from an employee or otherwise receiving actual notice of such conviction;

(vi) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program by any employee who is so convicted as required by Section 5154 of the Drug-Free Workplace Act of 1988;

(vii) Make a good-faith effort to continue a drug-free workplace through implementation of subparagraphs (J)(i) through (J)(vi);

(viii) Require any subcontractor to comply with subparagraphs (J)(i) through (J)(vii);

(ix) Neither the Provider, nor any of the Provider's employees, officers, agents or subcontractors may provide any service required under these rules while under the influence of drugs. For purposes of this provision, "under the influence" means observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the Provider or Provider's employee, officer, agent or subcontractor has used a controlled substance, prescription or non-prescription medication that impairs the Provider or Provider's employee, officer, agent or subcontractor's performance of essential job function or creates a direct threat to DHS Clients or others. Examples of abnormal behavior include, but are not limited to hallucinations, paranoia or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to slurred speech, difficulty walking or performing job activities;

(x) Violation of any provision of this subsection may result in termination of the Provider agreement under these rules.

(K) The Provider must comply and cause all sub-contractors to comply with the Pro-Children Act of 1994 (codified at 20 USC section 6081 et. seq.);

(L) The Provider must comply with all applicable federal and state laws and regulations pertaining to the provision of Medicaid Services under the

Medicaid Act, Title XIX, 42 USC Section 1396 et. Seq., including without limitation:

(i) Keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving Medicaid assistance and must furnish such information to any state or federal agency responsible for administering the Medicaid program regarding any payments claimed by such person or institution for providing Medicaid Services as the state or federal agency may from time to time request. 42 USC Section 1396a(a)(27); 42 CFR 431.107(b)(1) & (2);

(ii) Comply with all disclosure requirements of 42 CFR 1002.3(a) and 42 CFR 455 Subpart (B);

(iii) Maintain written notices and procedures respecting advance directives in compliance with 42 USC Section 1396(a)(57) and (w), 42 CFR 431.107(b)(4), and 42 CFR 489 subpart I;

(iv) Certify when submitting any claim for the provision of Medicaid Services that the information submitted is true, accurate and complete. The Provider must acknowledge Provider's understanding that payment of the claim will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

(2) Hospitals, Nursing Facilities, Home Health Agencies (including those providing personal care), Hospices and Health Maintenance Organizations will comply with the Patient Self-Determination Act as set forth in Section 4751 of OBRA 1991. To comply with the obligation under the above listed laws to deliver information on the rights of the individual under Oregon law to make health care decisions, the named Providers and organizations will give capable individuals over the age of 18 a copy of "Your Right to Make Health Care Decisions in Oregon," copyright 1993, by the Oregon State Bar Health Law Section. Out-of-State Providers of these services should comply with Medicare and Medicaid regulations in their state. Submittal to DMAP of the appropriate billing form requesting payment for medical services provided to a Medicaid eligible Client shall be deemed representation to DMAP of the medical Provider's compliance with the above-listed laws.

(3) Providers described in ORS chapter 419B are required to report suspected child abuse to their local DHS Children, Adults and Families office or police, in the manner described in ORS 419.

(4) The Clinical Laboratory Improvement Act (CLIA), requires all entities that perform even one laboratory test, including waived tests on, "materials derived 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" to meet certain federal requirements. If an entity performs tests for these purposes, it is considered, under CLIA to be a laboratory.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
1-1-07

410-120-1385 Compliance with Public Meetings Law

(1) Advisory committees with the authority to make decisions for, conduct policy research for, or make recommendations on administration or policy related to the medical assistance programs operated by the Department of Human Services (DHS) pursuant to ORS Chapter 414 must comply with provisions of ORS 192.610 to 192.690 - Public Meetings Law.

(2) This rule applies to those advisory committees of the medical assistance programs operated under ORS Chapter 414 that are both:

(a) Created by state constitution, statutes, administrative rule, order, intergovernmental agreement, or other official act, including direct or delegated authority from the Director of DHS; and

(b) Comprised of at least two committee members who are not employed by a public body.

(3) Advisory committees subject to this rule must comply with the following provisions:

(a) Meetings must be open to public attendance unless an executive session is authorized. Committees must meet in a place accessible to persons with disabilities and, upon request, shall make a good faith effort to provide a sign language interpreter for persons with hearing impairment.

(b) Groups must provide advanced notice of meetings, location, and principal subjects to be discussed. Posting notices on the Web site operated by the DHS Division of Medical Assistance Programs (DMAP) will be sufficient compliance of the advanced notice requirement. Interested persons, including news media, may request hard copy notices by contacting the DMAP Communications Unit;

(c) Groups must take minutes at meetings and make them available to the public upon request to the contact person identified on the public notice;

(d) Any meeting that is held through the use of telephone or other electronic communication must be conducted in accordance with the Public Meetings Law.

Stat. Auth.: ORS 409
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1-1-07

410-120-1390 Premium Sponsorships

(1) Premium donations made for the benefit of one or more specified Division of Medical Assistance Programs (DMAP) Clients will be referred to as a Premium Sponsorship and the donor shall be referred to as a sponsor.

(2) The Department of Human Services (DHS) may accept Premium Sponsorships consistent with the requirements of this rule. DHS may adopt such forms and reporting requirements, and change the forms and reporting requirements, as necessary to carry out its functions under this rule. DHS may identify one or more designees to perform one or more of the functions of DHS under this rule.

(3) This rule does not create or establish any Premium Sponsorship program. DHS does not operate or administer a Premium Sponsorship program. DHS does not find sponsors for Clients or take requests or applications from Clients to be sponsored.

(4) This rule does not create a right for any DMAP Client to be sponsored. Premium Sponsorship is based solely on the decisions of sponsors. DHS only applies the Premium Sponsorship funds that are accepted by DHS as instructed by the sponsor. DHS does not determine who may be sponsored. Any operations of a Premium Sponsorship program are solely the responsibility of the sponsoring entity.

(5) A Premium Sponsorship amount that is not actually received by the DMAP Client will not be deemed to be cash or other resource attributed to the DMAP Client, except to the extent otherwise required by federal law. An DMAP Client's own payment of his or her obligation, or payment made by an authorized representative of the DMAP Client, is not a sponsorship except to the extent that the authorized representative is otherwise subject to subsection (8) of this rule.

(6) Nothing in this rule alters the DMAP Client's personal responsibility for assuring that his or her own payments (including current or past due premium payments) are made on time as required under any DHS rule

(7) If DHS accepts a Premium Sponsorship payment for the benefit of a specified Client, DHS or its designee will credit the amount of the

sponsorship payment toward any outstanding amount owed by the specified Client. DHS or its designee is not responsible for notifying the Client that a Premium Sponsorship payment is made or that a sponsorship payment has stopped being made.

(8) If a sponsor is a health care Provider, or an entity related to a health care Provider, or an organization making a donation on behalf of such Provider or entity, the following requirements apply:

(a) DHS will decline to accept Premium Sponsorships that are not “bona fide donations” within the meaning of 42 CFR 433.54. A Premium Sponsorship is a “bona fide donation” if the sponsorship has no direct or indirect relationship to Medicaid payments made to a health care Provider, a related entity providing health care items or services, or other Providers furnishing the same class of items or services as the Provider or entity;

(b) For purposes of this rule, terms “health care Provider,” “entity related to a health care Provider” and “Provider-related donation” will have the same meaning as those terms are defined in 42 CFR 433.52. A health care Provider includes but is not limited to any Provider enrolled with DMAP or contracting with a Prepaid Health Plan for services to Oregon Health Plan Clients.

(c) Premium Sponsorships made to DHS by a health care Provider or an entity related to a health care Provider do not qualify as a “bona fide donation” within the meaning of subsection (a) of this section, and DHS will decline to accept such sponsorships;

(d) If a health care Provider or an entity related to a health care Provider donates money to an organization, which in turn donates money in the form of a Premium Sponsorship to DHS, the organization will be referred to as an organizational sponsor. DHS may accept Premium Sponsorship from an organizational sponsor if the organizational sponsor has completed the initial DHS certification process and complies with this rule. An organizational sponsor may not itself be a health care Provider, Provider-related entity, or a unit of local government;

(e) All organizational sponsors that make Premium Sponsorships to DHS may be required to complete at least annual certifications, but no more

frequently than quarterly. Reports submitted to DHS will include information about the percentage of its revenues that are from donations by Providers and Provider-related entities. The organization's chief executive officer or chief financial officer must certify the report. In its certification, the organizational sponsor must agree that its records may be reviewed to confirm the accuracy, completeness and full disclosure of the donations, donation amounts and sources of donations. DHS will decline to accept donations or gifts from an organization that refuses or fails to execute necessary certifications or to provide access to documentation upon request;

(f) DHS will decline to accept Premium Sponsorships from an organizational sponsor if the organization receives more than 25 percent of its revenue from donations from Providers or Provider-related entities during the State's fiscal year;

(g) Any health care Provider or entity related to a health care Provider making a donation to an organizational sponsor, or causing another to make a Premium Sponsorship on its behalf, and any organizational sponsor, is solely responsible for compliance with laws and regulations applicable to any donation, including but not limited to 42 CFR 1001.951 and 1001.952.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-120-1395 Program Integrity

(1) The Department of Human Services (DHS) uses several approaches to promote program integrity. These rules describe program integrity actions related to Provider payments. Our program integrity goal is to pay the correct amount to a properly enrolled Provider for covered, Medically Appropriate services provided to an eligible Client according to the Client's benefit package of health care services in effect on the date of service. Types of program integrity activities include but are not limited to the following activities:

(a) Medical review and Prior Authorization processes, including all actions taken to determine the medical appropriateness of services or items;

(b) Provider obligations to submit correct claims;

(c) Onsite visits to verify compliance with standards;

(d) Implementation of Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards to improve accuracy and timeliness of claims processing and encounter reporting;

(e) Provider credentialing activities;

(f) Accessing federal Department of Health and Human Services database (exclusions);

(g) Quality improvement activities;

(h) Cost report settlement processes;

(i) Audits;

(j) Investigation of fraud or prohibited kickback relationships;

(k) Coordination with the Department of Justice Medicaid Fraud Control Unit (MFCU) and other health oversight authorities;

(2) Providers must maintain clinical, financial and other records, capable of being audited or reviewed, consistent with the requirements of OAR 410-120-1360 Requirements for Financial, Clinical and Other Records, the General Rules, the Oregon Health Plan Administrative Rules, and the rules applicable to the service or item.

(3) The following people may review a request for services or items, or audit a claim for care, services or items, before or after payment, for assurance that the specific care, item or service was provided in accordance with the Division of Medical Assistance Program's (DMAP's) rules and the generally accepted standards of a Provider's field of practice or specialty:

(a) DHS staff or designee; or

(b) Medical utilization and review contractor; or

(c) Dental utilization and review contractor; or

(d) Federal or state oversight authority.

(4) Payment may be denied or subject to recovery if the review or audit determines the care, service or item was not provided in accordance with DMAP rules or does not meet the criteria for quality or medical appropriateness of the care, service or item or payment. Related Provider and Hospital billings will also be denied or subject to recovery.

(5) When the Department determines that an Overpayment has been made to a Provider, the amount of Overpayment is subject to recovery.

(6) The Department may communicate with and coordinate any program integrity actions with the MFCU, DHHS, and other federal and state oversight authorities.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-120-1397 Recovery of Overpayments to Providers - Recoupments and Refunds

(1) The Department of Human Services (DHS) requires Providers to submit true, accurate, and complete claims or encounters. DHS treats the submission of a claim or encounter, whether on paper or electronically, as certification by the Provider of the following: "This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim or encounter will be from federal and state funds, and that any falsification or concealment of a material fact maybe prosecuted under federal and state laws."

(2) DHS staff or a designee may review or audit a claim before or after payment for assurance that the specific care, item or service was provided in accordance with DHS the rules and policies, the terms applicable to the agreement or contract and the generally accepted standards of a Provider's field of practice or specialty:

(a) "Designee" for the purposes of these rules includes, but is not limited to, a medical, behavioral, drug or dental utilization and review or a post-payment review contractor;

(b) "Claim" for the purposes of these rules includes requests for payment under a Provider enrollment agreement or contract, whether submitted as a claim or invoice or other method for requesting payment authorized by administrative rule, and may include encounter data.

(3) DHS may deny payment or may deem payments subject to recovery as an Overpayment if a review or audit determines the care, item, drug or service was not provided in accordance with DHS policy and rules applicable agreement, intergovernmental agreement or contract, including but not limited to the reasons identified in section (5)_ of this rule.. Related Provider and Hospital billings will also be denied or subject to recovery.

(4) If a Provider determines that a submitted claim or encounter is incorrect, the Provider is obligated to submit an Individual Adjustment Request and refund the amount of the Overpayment, if any, consistent with the requirements of OAR 410-120-1280. When the Provider determines that an Overpayment has been made, the Provider must notify and reimburse the

Department immediately, following one of the reimbursement procedures described below:

(a) Submitting a Medicaid adjustment form (DMAP 1036-Individual Adjustment Request) will result in an offset of future payments. It is not necessary to refund with a check if an offset of future payments is adequate to repay the amount of the Overpayment; or

(b) Providers preferring to make a refund by check must attach a copy of the remittance statement page indicating the Overpayment information, except as provided by subsection (c) of this section. If the Overpayment involves an insurance payment or another Third Party Resource, Providers will attach a copy of the remittance statement from the insurance payer:

(A) Refund checks not involving Third Party Resource payments will be made payable to DMAP Receipting - Checks in Salem;

(B) Refunds involving Third Party Resource payments will be made payable and submitted to DMAP Receipting - MPR Checks in Salem;

(c) Providers making a refund by check based on audit or post-payment review will follow the reimbursement procedures described in the Overpayment notice or order in the audit or on post-payment review, if specified.

(5) DHS may determine, as a result of review or other information, that a payment should be denied or that an Overpayment has been made to a Provider, which indicates that a Provider may have submitted claims or encounters, or received payment to which the Provider is not properly entitled. Such payment denial or Overpayment determinations may be based on, but not limited to, the following grounds:

(a) DHS paid the Provider an amount in excess of the amount authorized under the state plan or DHS rule, agreement or contract;

(b) A third party paid the Provider for services (or a portion thereof) previously paid by DHS;

(c) DHS paid the Provider for care, items, drugs or services that the Provider did not perform or provide;

(d) DHS paid for claims submitted by a data processing agent for whom a written Provider or Billing Agent/Billing Service agreement or other applicable contract or agreement was not on file at the time of submission;

(e) DHS paid for care, items, drugs or services and later determined they were not part of the client's benefit package;

(f) Coding, processing submission or data entry errors;

(g) The care, items, drugs or service was not provided in accordance with DHS rules or does not meet the criteria for quality of care, item, drug or service, or medical appropriateness of the care, item, drug, service or payment;

(h) DHS paid the Provider for care, items, drugs or services, when the Provider did not comply with DHS rules and requirements for reimbursement.

(6) Prior to identifying an Overpayment, the Department or designee may contact the Provider for the purpose of providing preliminary information and requesting additional documentation. Provider must provide the requested documentation within the time frames requested.

7) When an Overpayment is identified, DHS will notify the Provider in writing, as to the nature of the discrepancy, the method of computing the dollar amount of the Overpayment, and any further action that the Department may take in the matter:

(a) The DHS notice may require the Provider to submit applicable documentation for review prior to requesting an appeal from DHS, and may impose reasonable time limits for when such documentation must be provided in order to be considered by DHS.

(b) The Provider may appeal a DHS notice of Overpayment in the manner provided in OAR 410-120-1560.

(7) DHS may recover Overpayments made to a Provider by direct reimbursement, offset, civil action, or other actions authorized by law:

(a) The Provider must make a direct reimbursement to DHS within thirty (30) calendar days from the date of the notice of the Overpayment, unless other regulations apply;

(b) DHS may grant the Provider an additional period of time to reimburse DHS upon written request made within thirty (30) calendar days from the date of the notice of Overpayment if the Provider provides a statement of facts and reasons sufficient to show that repayment of the Overpayment amount should be delayed pending appeal because:

(i) The Provider will suffer irreparable injury if the Overpayment repayment is not delayed;

(ii) There is a plausible reason to believe that the overpayment is not correct or is less than the amount in the notice, and the Provider has timely filed an appeal of the Overpayment, or that Provider accepts the amount of the Overpayment but is requesting to make repayment over a period of time;

(iii) A proposed method for assuring that the amount of the Overpayment can be repaid when due with interest, including but not limited to a bond, irrevocable letter of credit or other undertaking, or a repayment plan for making payments including interest over a period of time.

(iv) Granting the delay will not result in substantial public harm;

(v) Affidavits containing evidence relied upon in support of the request for stay:

(vi) DHS may consider all information in the record of the Overpayment determination, including Provider cooperation with timely provision of documentation, in addition to the information supplied in Provider's request. If Provider requests a repayment plan, DHS may require conditions

acceptable to DHS before agreeing to a repayment plan. DHS must issue an order granting or denying a repayment delay request within thirty (30) calendar days after receiving it.

(c) Except as otherwise provided in subsection (b) a request for a hearing or administrative review does not change the date the repayment of the Overpayment is due, and if the outcome of the appeal reduces the amount of the Overpayment, that amount previously paid by the Provider in response to the notice of Overpayment will be refunded to the Provider;

(d) DHS may withhold payment on pending claims and on subsequently received claims for the amount of the overpayment when Overpayments are not paid as a result of Section (7)(a);

(e) DHS may file a civil action in the appropriate Court and exercise all other civil remedies available to DHS in order to recover the amount of an overpayment.

(89 In addition to any Overpayment, DHS may impose a Sanction on the Provider in connection with the actions that resulted in the Overpayment. DHS may, at its discretion, combine a notice of Sanction with a notice of Overpayment.

(10) Voluntary submission of an Individual Adjustment Request or Overpayment amount after notice from the Department does not prevent the Department from issuing a notice of Sanction, but DHS may take such voluntary payment into account in determining the Sanction.

Stat. Auth.: ORS 409.010, 409.110 & 409.050

Stats. Implemented: ORS 414.025, 414.105, 414.106, 414.805

1-1-08

410-120-1400 Provider Sanctions

(1) The Department of Human Services (DHS) recognizes two classes of Provider Sanctions, mandatory and discretionary, outlined in (3) and (4) respectively.

(2) Except as otherwise noted, DHS will impose Provider Sanctions at the discretion of the DHS Director or the Administrator of the DHS Office whose budget includes payment for the services involved.

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

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

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

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

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

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

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

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

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

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

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

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

(f) Billed excessive charges (i.e., charges in excess of the Usual Charge); furnished items or services substantially in excess of the DMAP Client's needs or in excess of those services ordered by a medical Provider or in excess of generally accepted standards or of a quality that fails to meet professionally recognized standards;

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

(h) Failed to disclose required ownership information;

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

(j) Failed to supply requested payment information;

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

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

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

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

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

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

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

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

(i) Obtain greater payment than is appropriate;

(ii) Circumvent Prior Authorization requirements;

(iii) Charge more than the Provider's Usual Charge to the general public;

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

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

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

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

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

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

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

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

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

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

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

(w) Submitted false or fraudulent information when applying for an DMAP assigned Provider number, or failed to disclose information requested on the Provider enrollment application;

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

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

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

(aa) Failed to properly account for an DMAP Client's Personal Incidental Funds; including but not limited to using a Client's Personal Incidental Funds for payment of services which are included in a medical facility's All-Inclusive Rates;

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

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

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

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

(ff) Collected or made repeated attempts to collect payment from Clients for services covered by DMAP, per OAR 410-120-1280, Billing.

(5) A Provider who has been excluded, suspended or terminated from participation in a federal or state medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, shall not submit claims for payment, either personally or through claims submitted by any Billing Agent/Service, Billing Provider or other Provider, for any services or supplies provided under the medical assistance programs, except those services or supplies provided prior to the date of exclusion, suspension or termination.

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 409.010

1-1-07

410-120-1460 Type and Conditions of Sanction

(1) The Division of Medical Assistance Programs (DMAP) may impose mandatory Sanctions on a Provider pursuant to OAR 410-120-1400(3), in which case:

(a) The Provider will be either Terminated or Suspended from participation in Oregon's medical assistance programs;

(b) If Suspended, the minimum duration of Suspension will be determined by the Secretary of the Department of Health and Human Services (DHHS), under the provisions of 42 CFR Parts 420, 455, 1001, or 1002. The State may suspend a Provider from participation in Oregon's medical assistance programs longer than the minimum Suspension determined by the DHHS Secretary.

(2) DMAP may impose the following discretionary Sanctions on a Provider pursuant to OAR 410-120-1400(4):

(a) The Provider may be Terminated from participation in Oregon's medical assistance programs;

(b) The Provider may be Suspended from participation in Oregon's medical assistance programs for a specified length of time, or until specified conditions for reinstatement are met and approved by DMAP;

(c) DMAP may withhold payments to a Provider;

(d) The Provider may be required to attend Provider education sessions at the expense of the Sanctioned Provider;

(e) DMAP may require that payment for certain services are made only after DMAP has reviewed documentation supporting the services;

(f) DMAP may recover investigative and legal costs;

(g) DMAP may provide for reduction of any amount otherwise due the Provider; and the reduction may be up to three times the amount a Provider sought to collect from a Client in violation of OAR 410-120-1280;

(h) Any other Sanctions reasonably designed to remedy or compel future compliances with federal, state or DMAP regulations.

(3) DMAP will consider the following factors in determining the Sanction(s) to be imposed (this list includes but is not limited to these factors):

(a) Seriousness of the offense(s);

(b) Extent of violations by the Provider;

(c) History of prior violations by the Provider;

(d) Prior imposition of Sanctions;

(e) Prior Provider education;

(f) Provider willingness to comply with program rules;

(g) Actions taken or recommended by licensing boards or a Quality Improvement Organization (QIO); and

(h) Adverse impact on the health of DMAP Clients living in the Provider's service area.

(4) When a Provider fails to meet one or more of the requirements identified in this rule DMAP, at its sole discretion, may immediately suspend the Provider’s DMAP assigned billing number to prevent public harm or inappropriate expenditure of public funds:

(a) The Provider subject to immediate Suspension is entitled to a contested case hearing as outlined in 410-120-1600 through 410-120-1700 to determine whether the Provider's DMAP assigned number will be revoked;

(b) The notice requirements described in section (5) of this rule do not preclude immediate suspension at DMAP’s sole discretion to prevent public harm or inappropriate expenditure of public funds. Suspension may be invoked immediately while the notice and contested case hearing rights are exercised.

(5) If DMAP decides to sanction a Provider, DMAP will notify the Provider by certified mail or personal delivery service of the intent to Sanction. The notice of immediate or proposed Sanction will identify:

(a) The factual basis used to determine the alleged deficiencies;

(b) Explanation of actions expected of the Provider;

(c) Explanation of subsequent actions DMAP intends to take;

(d) The Provider's right to dispute DMAP's allegations, and submit evidence to support the Provider's position; and

(e) The Provider's right to appeal DMAP's proposed actions pursuant to OARs 410-120-1560 through 410-120-1700.

(6) If DMAP makes a final decision to Sanction a Provider, DMAP will notify the Provider in writing at least 15 days before the effective date of action, except in the case of immediate suspension to avoid public harm or inappropriate expenditure of funds.

(7) The Provider may appeal DMAP’s immediate or proposed Sanction(s) or other action(s) the Department intends to take, including but not limited to the following list. The Provider must appeal these actions separately from any appeal of audit findings and overpayments:

(a) Termination or Suspension from participation in the Medicaid-funded medical assistance programs;

(b) Termination or Suspension from participation in DMAP’s state-funded programs;

(c) Revocation of the Provider’s DMAP assigned Provider number.

(8) Other provisions:

(a) When a Provider has been Sanctioned, all other Provider entities in which the Provider has ownership (five percent or greater) or control of, may also be Sanctioned;

(b) When a Provider has been Sanctioned, DMAP may notify the applicable professional society, board of registration or licensure, federal or state agencies, Oregon Health Plan Prepaid Health Plans and the National Practitioner Data Base of the findings and the Sanctions imposed;

(c) At the discretion of DMAP, Providers who have previously been Terminated or Suspended may or may not be re-enrolled as DMAP Providers;

(d) Nothing in this rule prevents the Department from simultaneously seeking monetary recovery and imposing Sanctions against the Provider;

(e) If DMAP discovers continued improper billing practices from a Provider who, after having been previously warned in writing by DMAP or the Department of Justice about improper billing practices and has had an opportunity for a contested case hearing, that Provider will be liable to DMAP for up to triple the amount of DMAP's established overpayment received as a result of such violation.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 409.010

1-1-07

410-120-1505 Provider Audits

(1) Providers receiving payments from the Division of Medical Assistance Programs (DMAP) are subject to audit for all payments applicable to services rendered or items supplied to or on behalf of DMAP Clients. The audit ensures that proper payments were made on the basis of the requirements applicable to covered services, to recover Overpayments, and to discover possible instances or Fraud and Abuse.

(2) The Department may employ such staff, consultants, contractors or other designee, as it deems appropriate, to conduct an audit. The Department will identify one or more persons assigned to conduct the audit. For purposes of these rules, the person assigned to conduct the audit will be referred to as the Auditor.

(3) The Auditor determines the scope and time period covered by the audit.

(4) The Auditor may conduct an on-site visit, examine and copy records and documents, interview employees, and conduct such field work as it determines will provide a sufficient and competent evidential basis for drawing conclusions about the subject matter of the audit.

(5) The Auditor may consider other audits of the Provider, including but not limited to the Provider's independent auditors of the Provider's financial statements, but may include those performed by internal auditors or audit organizations established by the federal or state government for programs other than Medicaid. The Auditor may also consider other indicators such as Prior Authorization issues related to program integrity activities., and whether past or present program integrity activities such as those listed in OAR 410-120-1395 have identified the same or similar instances of non-compliance. The Auditor is responsible for evaluating the reliability of the other audit work, and to consider the scope of the other audit and its relationship to the scope and objective of the audit being conducted by the Department, in determining the weight to be given to the other audit work.

(6) The Auditor may use a random sampling method such as that detailed in the paper entitled "Development of a Sample Design for the Post-Payment Review of Medical Assistance Payments," written by Lyle Calvin, Ph.D., (a.k.a., Calvin Paper). The Department of Human Services (DHS)

hereby adopts by reference, but is not limited to, the method of random sampling and calculation of Overpayment described in the Calvin Paper.
(a) In determining whether to use the Overpayment calculation method set forth in subsection (6) of this rule, the Department may consider:

(A) The Provider's overall error rate identified in the audit;

(B) Whether past audits have identified same or similar instances of non-compliance;

(C) The severity of the errors;

(D) Adverse impact on the health of DMAP Clients and their access to services in the Provider's service area.

(b) If the Auditor determines an Overpayment amount by the random sampling and Overpayment calculation method set forth in subsection (6) of this rule, the Provider may request a 100 percent audit of all billings submitted to DMAP for services provided during a period specified by the DHS Auditor. If a 100 percent audit is requested:

(A) Payment and arrangement for a 100 percent audit is the responsibility of the Provider requesting the audit; and

(B) The audit must be conducted by an Auditor (such as a certified public accountant or other person designated as the Auditor) whose qualifications DHS has determined, in writing, to be acceptable, who is knowledgeable with the Oregon Administrative Rules covering the payments in question, and the Provider must waive any privilege in relation to the work papers and work product of the Auditor; and

(C) The audit must be conducted within 120 calendar days of the Provider's request to use such audit in lieu of the Department's random sample.

(7) The Auditor will prepare a preliminary audit report and send it to the Provider for review and comment. The preliminary audit report will inform the Provider of the opportunity to provide additional information to the Auditor about the information within the scope of the audit report, and to

permit the Provider to request a meeting with the Auditor to review the preliminary audit report.

(8) The Auditor will prepare a final audit report and include an Overpayment assessment, where applicable. The amount of audit Overpayment to be recovered:

(a) Will be the entire amount determined or agreed to by the Department; and

(b) Is not limited to amount(s) determined by criminal or civil proceedings;

(c) Will include interest to be charged at allowable state rates.

(9) The final audit report will be delivered to the Provider in person or by registered or certified mail.

(10) If the Provider disagrees with the final audit report or the amount of Overpayment, the Provider may appeal the decision by requesting an administrative review from DMAP, unless DMAP declines to conduct an administrative review, then the Provider may appeal to a contested case hearing. In general, appeals limited to legal or policy issues may be appropriate for administrative review. Appeals that require the decision-maker to resolve disputed factual issues and the development of a factual record should be appealed as a contested case.

(a) The Provider must submit to DMAP a written request for hearing or administrative review of the decision being appealed pursuant to OAR 410-120-1560, Provider Appeals. The request must specify the area(s) of disagreement;

(b) Failure to request either a hearing or an administrative review in a timely manner constitutes acceptance by the Provider of the final audit report, the amount of the Overpayment, and any Sanctions, if combined with the final audit report.

(11) The Overpayment is due and payable 30 calendar days from the date of the Department's decision:

(a) The Department may grant the Provider an additional 30-day grace period upon request;

(b) A request for a hearing or administrative review does not change the date the repayment of the overpayment is due.

(12) The Department may extend the reimbursement period or accept an offer of repayment terms. The Department must make any change in reimbursement period or terms in writing.

(13) If the Provider refuses to reimburse the overpayment or does not adhere to an agreed upon payment schedule, the Department may:

(a) Recoup future Provider payments up to the amount of the overpayment; and

(b) Pursue civil action to recover the overpayment.

(14) As the result of a hearing or review, the amount of the overpayment may be reduced in part or in full.

(15) The Department may, at any time, change the amount of the Overpayment upon receipt of additional information. The Department will verify any changes in writing. DMAP will refund to the Provider any monies paid to DMAP that exceed an Overpayment.

(16) If a Provider is terminated or sanctioned for any reason, the Department may pursue civil action to recover any amounts due and payable to DMAP.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 409.010

1-1-07

410-120-1510 Fraud and Abuse

(1) This rule sets forth requirements for detecting and investigating Fraud and Abuse. The terms Fraud and Abuse in this rule are defined in OAR 410-120-0000. As used in these rules, terms have the following meanings:

(a) "Conviction" or "convicted" means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending;

(b) "Exclusion" means that the Division of Medical Assistance Programs (DMAP) will not reimburse a specific Provider who has defrauded or abused DMAP for items or services that Provider furnished;

(c) "Prohibited kickback relationships" means remuneration or payment practices that may result in federal civil penalties or exclusion for violation of 42 CFR 1001.951;

(d) "Suspension" means DMAP will not reimburse a specified Provider who has been convicted of a program-related offense in a federal, state or local court for items or services that Provider furnished.

(2) Provider is required to promptly refer all suspected Fraud and Abuse, including Fraud or Abuse by its employees or in DMAP administration, to the Medicaid Fraud Control Unit (MFCU) of the Department of Justice or to the Department of Human Services (DHS) Audit Unit. The Department of Justice Medicaid Fraud Control Unit (MFCU) phone number is (503) 229-5725, address 1515 SW 5th Avenue, Suite 410, Portland, Oregon 97201, and fax is (503) 229-5459. The Department of Human Services Audit Unit phone number is (503) 945-6691, address 500 Summer St. NE, Salem, Oregon 97301-1097, and fax is (503) 947-5400.

(3) Provider shall permit the MFCU or DHS or both to inspect, copy, evaluate or audit books, records, documents, files, accounts, and facilities, without charge, as required to investigate an incident of Fraud or Abuse.

(4) Provider, if aware of suspected Fraud or Abuse by an DMAP Client (i.e., Provider reporting DMAP Client Fraud and Abuse) must report the incident to the Department Fraud Unit. Address suspected DMAP Client Fraud and

Abuse reports to the Department Fraud Investigation Unit, P.O. Box 14150, Salem, Oregon 97309-5027, or phone (503) 378-1872, or fax (503) 373-1525.

(5) The Department may share information for health oversight purposes with the MFCU and other federal or state health oversight authorities.

(6) The Department is authorized to take the actions necessary to investigate and respond to substantiated allegations of Fraud and Abuse, including but not limited to suspending or terminating the Provider from participation in the medical assistance programs, withholding payments or seeking recovery of payments made to the Provider, or imposing other Sanctions provided under state law or regulations. Such actions by the Department may be reported to the Centers for Medicare and Medicaid Services, or other federal or state entities as appropriate.

(7) Providers and their fiscal agents must disclose ownership and control information, and disclose information on a Provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid or the Title XX services program. Such disclosure and reporting is made a part of the Provider enrollment agreement, and the Provider is obligated to update that information with an amended Provider enrollment agreement if any of the information materially changes. The Department will use that information to meet the requirements of 42 CFR 455.100 to 455.106, and this rule must be construed in a manner that is consistent with the Department acting in compliance with those requirements.

(8) The Department will not pay for covered services provided by persons who are currently suspended, debarred or otherwise excluded from participating in Medicaid, Medicare, or SCHIP, or who have been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, or XX of the Social Security Act or related laws.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 409.010

1-1-07

410-120-1560 Provider Appeals

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

(a) “Provider” means a person or entity enrolled with DMAP, or under contract with DHS that is subject to these DMAP 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 DHS 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 DMAP 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 DMAP 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

(2) A Division of Medical Assistance Programs (DMAP) enrolled Provider may appeal a DMAP 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 of provider's application for new or continued participation in the Medical Assistance Program; or

(c) Sanctions imposed, or intended to be imposed, by the Medical Assistance program on a provider or provider entity; and

(d) DMAP 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 DMAP.

(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 DMAP decision or from a Prepaid Health Plan (PHP) Provider expressing disagreement with a decision by a PHP.

(b) The request should identify the decision made by DMAP or a 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 DMAP within 180 calendar days of the date of the DMAP decision or the date of the PHP decision on the Provider's appeal to the PHP.

(5) Types and methods for Provider Appeals are listed below.

(a) A Division of Medical Assistance Programs (DMAP) denial of or limitation of payment allowed, DMAP claim decision including prior authorization decision, or DMAP 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 DMAP agrees to review the appeal of the notice of Sanction as an administrative review.

(c) All Provider appeals of DMAP decisions not described in paragraphs (4)(a) or (b) are handled as administrative reviews in accordance with OAR 410-120-1580, unless DMAP issues an order granting a contested case hearing.

(6) Decisions that adversely affect a Provider may be made by different program areas within DHS.

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

(b) Other program areas within DHS 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 DMAP by DHS contractors such as the DMAP 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 DMAP in which DMAP has legal authority to make the final decision in the matter, a Provider may appeal such a decision to DMAP as an administrative review and DMAP may accept such review.

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

(e) DMAP provides limited Provider appeals for Prepaid Health Plan Providers (PHP Providers) or non-participating providers concerning a decision by a Prepaid Health Plan (PHP). In general, the relationship between a PHP and PHP Providers is a contract matter between them. Client appeals are handled under the client appeal rules, not Provider appeal rules.

(i) The PHP Provider seeking a Provider Appeal must have a current valid provider enrollment agreement with DMAP and, unless the Provider is a non-participating provider, must also have a contract with the Prepaid Health Plan as a PHP Provider; and

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

(iii) The PHP Provider appeal or non-participating provider appeal from a 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 DMAP Provider appeal process does not include PHP payment or claims reimbursement amount issues, except in relation to non-participating provider matters governed by DMAP rule.

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

(7) In the event a request for Provider appeal is not timely, DMAP will determine whether the failure to file the request was caused by circumstances beyond the control of the Provider, Provider Applicant or PHP Provider. In determining whether to accept a late request for review, DMAP requires the request to be supported by a written statement that explains why the request for review is late. DMAP may conduct such further inquiry as DMAP deems appropriate. In determining timeliness of filing a request for review, the amount of time that DMAP determines

accounts for circumstances beyond the control of the Provider is not counted. DMAP 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 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 DMAP.

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

Stats. Implemented: ORS 409.010

7-1-09

410-120-1570 – Claim re-determinations

(1) If a Department of Human Services (DHS) Division of Medical Assistance Program (DMAP) provider disagrees with an initial claim determination, they may request either a technical or a medical re-determination, but not both. The provider must choose which type of review is being requested.

(a) The DMAP will not treat a technical review as a medical review request, or a medical review request as a technical review request.

(b) This rule does not apply to actions that 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.

(2) The request to reopen an initial claim determination for a technical or medical re-determination review must be made through DMAP Provider Services unit in writing or via telephone (followed with written request and materials required under this rule and provided within 7 calendar days of the date of the telephone request). All requests and required materials for either technical or medical re-determination must be received by the DMAP Provider Services unit within 180 days from the DMAP original claims adjudication decision.

(3) Technical re-determination reviews do not include medical re-determination review under (4) below.

(a) Technical reviews address such issues as;

(A) Mathematical or mechanical errors;

(B) Transposed procedure or diagnosis codes;

(C) Inaccurate data entry;

(D) Misapplication of a fee schedule;

(E) Computer errors;

(F) Denial of claims as duplicates that the party believes were incorrectly identified as a duplicate; or

(G) Incorrect data items, such as provider number, use of a modifier or date of service, unit changes or incorrect charges; (H) Errors with the Medicaid Management Information System (MMIS) (i.e. a code is missing in MMIS that the Oregon Health Services Commission (HSC) has placed on the Prioritized List of Health Services;

(H) Services not funded in the OHP Benefit package;

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

(J) Service denials related to program rules and limitations;

(b) The written request for technical re-determination review must include applicable claims submission, remittance advice data, and any additional information or explanation necessary to describe the alleged error. This information must be submitted to DMAP at the time of the request for technical re-determination review. DMAP may request additional information from the provider that it finds relevant to the request under review. DMAP will respond to the request for technical re-determination review in writing.

(4) Medical re-determination reviews do not include technical re-determination review under (3) above. The provider requesting a medical re-determination review must submit the request in writing to DMAP, Provider Services Unit within 90 days from the DMAP decision.

(a) The request for medical re-determination review of a claim denial must include a letter of explanation identifying the specific re-determination denial issue identified in (b).with the specific service, supply or item being denied and include all relevant codes and detailed justification for funding of the denied service. At the time of request, the provider must include a copy of the denial decision or remittance advice that describes the basis for the claim denial under re-determination, and any information pertinent to the resolution of the medical re-determination review dispute, including

medical documentation and any applicable evidence-based practice literature that is consistent with the decision under review. DMAP will conduct the review, including any further inquiry that DMAP deems appropriate.

(b) A provider requesting medical 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, that is considered medically appropriate and related to an existing funded condition;

(C) A service not listed on the HSC Prioritized List may be covered under OAR 410-141-0480(10);(D) A service is a Medically appropriate diagnostic services;

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

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

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

(G) A service 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.

(c) At the time their request for review is made, providers, physicians and suppliers are responsible for providing the technical or medical information needed to adjudicate their claims, including relevant medical records and evidence-based practice data to support the position being asserted on review. Medical review will not be completed unless the claim has no

technical errors. DMAP may request additional information that it finds relevant to the review.

(5) Technical or medical re-determination review is based on the DMAP review of documentation and applicable law. DMAP does not provide a face-to-face meeting with providers as part of the review process.

(a) The provider is responsible for the timely submission of its review request and all information pertinent to conducting the review, consistent with the requirements of this rule.

(b) DMAP will notify a provider requesting a technical or medical review of a denial of the review request 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;

(C) The provider fails to submit requested information within the required timelines.

(6) If the recipient is enrolled in a Prepaid Health Plan (PHP) and the claim was denied by a PHP, the provider requesting review must contact the PHP in accordance with 410-120-1560.

(7) The department'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 department's final decision under this rule.

Stat. Auth.: ORS.409.040, 409.050, 409.110, 409.120

Stat. Implemented: 414.065

7-1-09

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 (DMAP) or designee to review a DMAP decision affecting the Provider, Provider Applicant, 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 DMAP 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 DMAP 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 DMAP in the administrative review, the Provider, Provider Applicant or PHP Provider must provide DMAP (and any PHP, if applicable) with a copy of all relevant records, DMAP 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 or PHP Provider (and PHP, if applicable) and DMAP 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 PHP (when Client is enrolled in a PHP) of the date, time, and place the meeting is scheduled. The 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 DMAP 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) DMAP staff will not be available for cross-examination, but DMAP staff may attend and participate in the review meeting;

(e) Failure to appear without good cause constitutes acceptance of DMAP'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 DMAP Administrator or designee may request the Provider, Provider Applicant 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 PHP when review involved a 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 DMAP.

(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 409.040, 409.50, 409.110

Stats. Implemented: ORS 414.065

7-1-09

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 reconsideration or Administrative Review, or Client Appeal, DMAP will refer the request to the proper appeal procedure and notify the Provider, Provider Applicant 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 or PHP Provider who requested the appeal. In the event that DMAP determines that a PHP Provider is entitled to a Contested Case Hearing under OAR 410-120-1560, the PHP Provider and the PHP are parties to the hearing. A Provider, PHP Provider or PHP that is a corporation may be represented by any of the persons identified in ORS 410.190.

(4) Informal Conference: DMAP may notify the Provider(s) Provider Applicant or PHP Provider (and 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 DHS understand the specific reason for the action of the hearing request;

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

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

(e) The Provider, Provider Applicant or PHP Provider (or PHP, if applicable) may, at any time prior to the hearing date, request an additional informal conference with DMAP and DHS representative(s), which may be granted if DMAP 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 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 the DMAP 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 DMAP unless prior to the hearing, DMAP 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 DMAP, or the ALJ when the ALJ is authorized to issue the final order. The exceptions must be in writing and received by DMAP, 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 DMAP.

(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 DMAP notifies the parties and the ALJ that DMAP will issue the final order. After receiving the exceptions or argument, if any, DMAP may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, DMAP 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 409.040, 409.050, 409.110 & 409.120

Stats. Implemented: ORS 414.065

7-1-09

410-120-1855 Client's Rights and Responsibilities

(1) Division of Medical Assistance Programs (DMAP) Clients shall have the following rights:

(a) To be treated with dignity and respect;

(b) To be treated by Providers the same as other people seeking health care benefits to which they are entitled;

(c) To refer oneself directly to mental health, chemical dependency or Family Planning services without getting a referral from a Primary Care Practitioner (PCP) or other Provider;

(d) To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines;

(e) To be actively involved in the development of his/her treatment plan;

(f) To be given information about his/her condition and covered and Non-Covered Services to allow an informed decision about proposed treatment(s);

(g) To consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services;

(h) To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

(i) To have written materials explained in a manner that is understandable to the DMAP Client;

(j) To receive necessary and reasonable services to diagnose the presenting condition;

(k) To receive DMAP covered services that meet generally accepted standards of practice and are Medically Appropriate;

(l) To obtain covered Preventive Services;

(m) To receive a referral to specialty Providers for Medically Appropriate covered services;

(n) To have a clinical record maintained which documents conditions, services received, and Referrals made;

(o) To have access to one's own clinical record, unless restricted by statute;

(p) To transfer of a copy of his/her clinical record to another Provider;

(q) To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, chemical dependency or mental health treatment and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990 -- Patient Self-Determination Act;

(r) To receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations;

(s) To know how to make a Complaint, Grievance or Appeal with DMAP and receive a response as defined in OAR 410-120-1860 and 410-120-1865;

(t) To request an Administrative Hearing with the Department of Human Services (DHS);

(u) To receive a notice of an appointment cancellation in a timely manner;

(v) To receive adequate notice of DHS privacy practices.

(2) DMAP Clients shall have the following responsibilities:

(a) To treat the Providers and clinic's staff with respect;

(b) To be on time for appointments made with Providers and to call in advance either to cancel if unable to keep the appointment or if he/she expects to be late;

(c) To seek periodic health exams and preventive services from his/her PCP or clinic;

(d) To use his/her PCP or clinic for diagnostic and other care except in an Emergency;

(e) To obtain a Referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;

(f) To use Emergency Services appropriately

(g) To give accurate information for inclusion in the Clinical Record;

(h) To help the Provider or clinic obtain Clinical Records from other Providers which may include signing an authorization for release of information;

(i) To ask questions about conditions, treatments and other issues related to his/her care that is not understood;

(j) To use information to make informed decisions about treatment before it is given;

(k) To help in the creation of a treatment plan with the Provider;

(l) To follow prescribed agreed upon treatment plans;

(m) To tell the Provider that his or her health care is covered with DMAP before services are received and, if requested, to show the Provider the OMAP Medical Care Identification form;

(n) To tell the DHS worker of a change of address or phone number;

(o) To tell the DHS worker if the DMAP Client becomes pregnant and to notify the DHS worker of the birth of the DMAP Client's child;

(p) To tell the DHS worker if any family members move in or out of the household;

(q) To tell the DHS worker and Provider(s) if there is any other insurance available, changes of insurance coverage including Private Health Insurance (PHI) according to OAR 410-120-1960, and to complete required periodic documentation of such insurance coverage in a timely manner;

(r) To pay for Non-Covered Services under the provisions described in OAR 410-120-1200 and 410-120-1280;

(s) To pay the monthly OHP premium on time if so required;

(t) To assist DMAP in pursuing any TPR available and to pay DMAP the amount of benefits it paid for an injury from any recovery received from that injury;

(u) To bring issues, or Complaints or Grievances to the attention of the DMAP; and

(v) To sign an authorization for release of medical information so that DHS can get information which is pertinent and needed to respond to an Administrative Hearing request in an effective and efficient manner.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 409.065

1-1-07

410-120-1860 Contested Case Hearing Procedures

(1) These rules apply to all contested case hearings provided by the Division of Medical Assistance Programs (DMAP) involving a Client's medical or dental benefits, except as otherwise provided in OAR 410-141-0263. The hearings are conducted in accordance with the Attorney General's model rules at OAR 137-003-0501 and following. When the term "agency" is used in the Attorney General's model rules, it shall refer to DMAP for purposes of this rule. The method described in OAR 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.

(2) Medical Provider appeals and administrative reviews involving DMAP are governed by OAR 410-120-1560 through 410-120-1700 .

(3) Complaints and appeals for Clients requesting or receiving medical assistance from a Prepaid Health Plan (PHP) shall be governed exclusively by the procedures in OAR 410-0141-0260. This rule describes the procedures applicable when those Clients request and are eligible for an DMAP 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 Department 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 Fully Capitated Health Plan (FCHP), Physician Care Organization (PCO), Dental Care Organization (DCO) or Chemical Dependency Organization (CDO); 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(10) describing when a Client of a PHP may request a state hearing.

(b) To be timely, a request for a hearing is complete when DMAP receives the Department's Administrative Hearing request form (DHS 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, DMAP 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, DMAP requires the request to be supported by a written statement that explains why the request for hearing is late. DMAP may conduct such further inquiry as DMAP deems appropriate. In determining timeliness of filing a hearing request, the amount of time that DMAP determines accounts for circumstances beyond the control of the Client is not counted. DMAP 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, DMAP may enter an order accordingly. DMAP 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 PHP, the claimant's PHP;

(f) A Client may be represented by any of the persons identified in ORS 183.458. A 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 DHS Form 443.

(c) DMAP staff will request all relevant medical documentation and present the documentation obtained in response to that request to the DMAP Medical Director or the Medical Director's designee for review. The DMAP

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 DMAP 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 DMAP 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 DMAP 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 DMAP 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 DMAP 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 DMAP 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 Department representative, which

may be granted if the Department representative finds, in his or her sole discretion, that the additional informal discussion will facilitate the hearing process or resolution of disputed issues;

(c) DMAP 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 DMAP 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 DMAP, unless, prior to the hearing, DMAP 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 DMAP notifies the parties and the ALJ that DMAP 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 DMAP consideration:

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

(B) After receiving the exceptions, if any, DMAP may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, the Department 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. DMAP 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 are 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.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

410-120-1865 Denial, Reduction, or Termination of Services

(1) The purpose of this rule is to describe the requirements governing the denial, reduction or termination of medical assistance, and access to the Division of Medical Assistance Programs (DMAP) administrative hearings process, for Clients requesting or receiving medical assistance services paid for by the Department on a fee-for-service basis. Complaint and appeal procedures for Clients receiving services from a Prepaid Health Plan shall be governed exclusively by the procedures in OAR 410-0141-0260.

(2) When the Department authorizes a course of treatment or covered service, but subsequently acts (as defined in 42 CFR 431.201) to terminate, suspend or reduce the course of treatment or a covered service, the Department or its designee shall mail a written notice to the Client at least ten (10) calendar days before the date of the termination or reduction of the covered service unless there is documentation that the Client had previously agreed to the change as part of the course of treatment or as otherwise provided in 42 CFR 431.213.

(3) The written Client notice must inform the Client of the action the Department has taken or intends to take and reasons for the action; a reference to the particular sections of the statutes and rules involved for each reason identified in the notice; the Client's right to request an administrative hearing; an explanation of the circumstances under which benefits may continue pending resolution of the hearing; and how to contact the Department for additional information. The Department is not required to grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.

(4)The Department shall have the following responsibilities in relation to continuation or reinstatement of benefit under this rule:

(a) If the Client requests an administrative hearing before the effective date of the Client notice and requests that the services be continued, the Department shall continue the services. The service shall be continued until whichever of the following occurs first (but in no event should exceed ninety [90] days from the date of the Client's request for an administrative hearing):

(A) The current authorization expires; or

(B) A decision is rendered about the case that is the subject of the administrative hearing; or

(C) The Client is no longer eligible for medical assistance benefits, or the health service, supply or item that is the subject of the administrative hearing is no longer a covered benefit in the Client's medical assistance benefit package; or

(D) The sole issue is one of federal or state law or policy and the Department promptly informs the Client in writing that services are to be terminated or reduced pending the hearing decision.

(b) The Division shall notify the Client in writing that it is continuing the service. The notice shall inform the Client that if the hearing is resolved against the Client, the cost of any services continued after the effective date of the Client notice may be recovered from the Client pursuant to 42 CFR 431.230(b);

(c) The Department shall reinstate services if:

(A) The Department takes an action without providing the required notice and the Client requests a hearing;

(B) The Department does not provide the notice in the time required under section (2) of this rule and the Client requests a hearing within 10 days of the mailing of the notice of action; or

(C) The post office returns mail directed to the Client, but the Client's whereabouts become known during the time the Client is still eligible for services;

(D) The reinstated services must be continued until a hearing decision unless, at the hearing, it is determined that the sole issue is one of federal or state law or policy.

(d) The Department shall promptly correct the action taken up to the limit of the original authorization, retroactive to the date the action was taken, if the

hearing decision is favorable to the Client, or the Department decides in the Client's favor before the hearing.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-120-1870 Client Premium Payments

(1) All non-exempt Clients in the benefit group are responsible for payment of premiums as outlined in OAR 461-135-1120.

(2) Nonpayment of premium can result in a disqualification of benefits per OAR 461-135-1130.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

410-120-1875 Agency Hearing Representatives

(1) Subject to the approval of the Attorney General, an agency officer or employee is authorized to appear (but not make legal argument) on behalf of the Department in the following classes of hearings:

(a) Contested case hearings requested by Clients in accordance with OAR 410-120-1860 and 410-130-1865; and

(b) Contested case hearings involving Providers in accordance with OAR 410-120-1560 to 410-120-1700.

(2) Subject to the approval of the Attorney General, the Department of Human Services (DHS) Audit Manager responsible for the Division of Medical Assistance Programs (DMAP) audits is authorized to appear (but not make legal argument) on behalf of the Department in the following classes of hearings:

(a) DMAP Overpayment determinations made in an audit under OAR 410-120-1505 (Provider audit);

(b) DMAP Provider Sanction decisions made in conjunction with or in lieu of an overpayment determination in OAR 410-120-1505 (Provider audit).

(3) Legal argument as used in ORS 183.452 and this rule has the same meaning as defined in OAR 137-003-0008(1)(c) and (d) OAR 137-003-0545.

(4) When a Department officer or employee, or the DHS Audit Manager, represents the Department, the presiding officer will advise such representative of the manner in which objections may be made and matters preserved for appeal. Such advice is of a procedural nature and does not change applicable law on waiver or the duty to make timely objection. Where such objections involve legal argument, the presiding officer will provide reasonable opportunity for the Department officer or employee, or the DHS Audit Manager, to consult legal counsel and permit such legal counsel to file written legal argument within a reasonable time after the conclusion of the hearing.

Stat. Auth.: ORS 409

Statutes Implemented: ORS 414.065

1-1-07

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 et seq. governing Prepaid Health Plans (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 Department of Human Services (DHS) in order to achieve one or more of the following purposes:

(a) To implement and maintain PHP services.

(b) To ensure access to appropriate Medical Services which would otherwise not 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 DHS 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, DHS will seek prior federal approval of solicitations and/or contracts when DHS plans to acquire or enhance services or equipment that will be paid in whole or on part with federal funds.

(3) DHS is exempt from the Public Contracting Code for purposes of source selection pursuant to ORS 279A.025(2). DHS 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. DHS may use any method reasonably appropriate to the nature of the supply or service and the business needs of the Department 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;

(b) 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 DHS 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 DHS 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 DHS; 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, DHS 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 DHS determine contract approval authority.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
1-1-07

410-120-1920 Institutional Reimbursement Changes

(1) The Division of Medical Assistance Programs (DMAP) is required under federal regulations, 42 CFR 447, to submit specific assurances and related information to the Centers for Medicare and Medicaid Services (CMS) whenever it makes a significant change in its methods and standards for setting payment rates for Inpatient Hospital Services or long-term care facilities.

(2) A "significant change" is defined as a change in payment rates which affects the general method of payment to all Providers of a particular type or is projected to affect total reimbursement for that particular type of Provider by six percent or more during the 12 months following the effective date.

(3) Federal regulation specifies that a public notice will be published in one of the following:

(a) A state register similar to the Federal Register. For the Department of Human Services (DHS), the state register is the Oregon Bulletin published by the Secretary of State;

(b) The newspaper of widest circulation in each city with a population of 50,000 or more;

(c) The newspaper of widest circulation in the state, if there is no city with a population of 50,000 or more.

Stat. Auth.: ORS 184.750 & ORS 184.770

Stats. Implemented: ORS 409.010

1-1-07

410-120-1940 Interest Payments on Overdue Claims

(1) Upon request by the Provider, the Division of Medical Assistance Programs (DMAP) will pay interest on an overdue claim:

(a) A claim is considered "overdue" if DMAP does not make payment within 45 days of receipt of a Valid Claim;

(b) The interest rate shall be the usual rate charged by the Provider to the Provider's clientele, but not more than two-thirds (2/3) percent per month or eight percent per year.

(2) When billing DMAP for interest on an overdue Valid Claim, the Provider must furnish the following information in writing:

(a) Name of the service and the location the service was provided;

(b) The name of the Client who received the service;

(c) Client ID Number;

(d) Date of service;

(e) Date of initial valid billing of DMAP;

(f) Amount of billing on initial Valid Claim;

(g) DMAP Internal Control Number (ICN) of claim;

(h) Certification, signed by the Provider or the Provider's authorized agent, that the amount claimed does not exceed the usual overdue account charges assessed by the Provider to the Provider's clientele.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-120-1960 Payment of Private Insurance Premiums

(1) Payment of insurance policy premiums for Medicaid Clients or eligible applicants will allow for the purchase of, or continuation of a Client or eligible applicant's coverage by another third party.

(2) For purposes of this rule, an eligible applicant may be a non-Medicaid individual, for whom the Division of Medical Assistance Programs (DMAP) would pay the premium if it is necessary in order to enroll the DMAP Client in the health plan in accordance with this rule. DMAP may pay health insurance policy premiums or otherwise enter into agreements with other health insurance plans that comply with ORS 414.115 to 414.145 on behalf of eligible individuals when:

(a) The policy is a major medical insurance policy; and

(b) The payment of premiums and/or co-insurance and deductibles is likely to be Cost Effective, as determined under section (4) of this rule, i.e., that the estimated net cost to DMAP will be less than the estimated cost of paying Providers on a Fee-for-Service (FFS) or other basis.

(c) An eligible applicant may be a non-Medicaid individual in the household if payment of the premium including that individual is cost effective, and if it is necessary to include that individual in order to enroll the DMAP Client in the health plan.

(3) DMAP will not pay private health insurance premiums for:

a) Non-SSI institutionalized and waivered Clients whose income deduction is used for payment of health insurance premiums;

b) Clients eligible for reimbursement of Cost-Effective, employer-sponsored health insurance (OAR 461-135-0990).

(4) DMAP will assure that all Medicaid covered services continue to be made available to Medicaid-eligible individuals for whom DMAP elects to purchase insurance.

(5) Assessment of Cost Effectiveness will include:

(a) The past utilization experience of the Client or eligible applicant as determined by past DMAP and third party insurance utilization and claims data; and

(b) The current and probable future health status of the Client or eligible applicant based upon existing medical conditions, previous medical history, age, number of dependents, and other relevant health status indicators; and

(c) The coverage of benefits, premium costs, copayments and coinsurance provisions, restrictions and other policies of the health insurance plans being considered.

(6) DMAP may purchase documents or records necessary to establish or maintain the Client's eligibility for other insurance coverage.

(7) DMAP will not make payments for any benefits covered under the private health insurance plan, except as follows:

(a) DMAP will calculate DMAP’s allowable payment for a service. The amount paid by the other insurer will be deducted from the DMAP allowable. If the DMAP allowable exceeds the third party payment, DMAP will pay the Provider of service the difference;

(b) The payment made by DMAP will not exceed any co-insurance, Copayment or deductible due;

(c) DMAP will make payment of co-insurance, Copayments or deductibles due only for covered services provided to Medicaid-eligible Clients.

(8) DMAP payment under this rule requires the Client to promptly inform the DHS worker, within 10 days, of any change of insurance coverage to minimize overpayment; the DHS worker, in turn, must promptly notify the PHI coordinator.

(9) As a condition of eligibility, Clients are required to pursue assets (OAR 461-120-0330), and required to obtain medical coverage (OAR 461-120-0345). Failure to notify the DHS worker of insurance coverage or changes

in such coverage, and failure to provide periodic required documentation for PHI may impact continued eligibility.

(10) The effective date for starting reimbursement of cost-effective Private Health Insurance (PHI) premiums is one of the following:

(a) For new cases, the later of the following:

(A) The date of request; or

(B) If no member of the filing group is eligible for medical on the date of request, the date of initial medical eligibility.

(b) For ongoing cases, the later of the following:

(A) The first of the month in which the insurance becomes effective; or

(B) The first of the month in which the benefit group requests reimbursement.

(11) The Client or eligible applicant's receipt of payment under this rule is intended for the express purpose of insurance premium payment, or reimbursement of Client paid insurance premium.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.115

1-1-07

410-120-1980 Requests for Information and Public Records

(1) The Division of Medical Assistance Programs (DMAP) will make non-exempt public records available for inspection to persons making a public records request under ORS 192.410 to 192.500.

(2) DMAP may charge a fee for copies of non-exempt public records to cover actual costs per OAR 407-003-0010.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 192.410 - ORS 192.500

6-1-07